Supreme Court, U.S.
FILED
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No. 02-215

IN THE

Supreme Court of the United States

IN RE HUMANA INC., MANAGED CARE LITIGATION
PACIFICARE HEALTH SYSTEM, INC. *et al.*
Petitioners,

v.

JEFFREY BOOK, D.O., *et al.*
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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JOINT APPENDIX

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MIAMI

Case No. ___

PACIFICARE HEALTH SYSTEMS, INC., *et al.*,
Petitioners,

v.

JEFFREY BOOK, D.O. *et al.*,
Respondents.

DOCKET ENTRIES

DATE	NO.	PROCEEDINGS
11/22/02	1740	RESPONSE by Provider Plaintiffs to [1696-1] motion to strike [1637-1] notice of dismissal, and [1696-2] motion for involuntary dismissal with prejudice of arbitrable claims (wc) [Entry date 11/25/02]
11/20/02	1737	MOTION with memorandum in support by United Healthcare for reconsideration of [1705-1] order granting Plaintiffs' motion to enjoin arbitration for stay of Provider Track discovery (wc) [Entry date 11/21/02]
11/15/02	1730	OPPOSITION by Provider Plaintiffs to United Healthcare, Inc.'s and United Health Group Inc.'s Supplemental Motion to Dismiss and Notice of its Renewal of its motions to compel arbitration and to stay proceedings pending arbitration (wc) [Entry date 11/18/02]

DATE	NO.	PROCEEDINGS
11/15/02	1729	RESPONSE by Provider Plaintiffs to [1651-1] notice of renewal of its motions to compel arbitration (wc) [Entry date 11/18/02]
11/15/02	1728	OPPOSITION by Provider Plaintiffs to [1653-1] motion to compel arbitration, [1653-2] motion to dismiss claims, [1653-3] motion to stay proceedings pending arbitration (wc) [Entry date 11/18/02]
11/15/02	1727	OPPOSITION by Provider Plaintiffs to [1668-1] renewed motion to compel arbitration (wc) [Entry date 11/18/02]
11/15/02	1726	RESPONSE by Provider Plaintiffs to [1663-1] notice of renewal of its motions to compel arbitration (wc) [Entry date 11/18/02]
11/15/02	1725	OPPOSITION by Provider Plaintiffs to [1649-1] second motion to compel arbitration (wc) [Entry date 11/18/02]
11/15/02	1724	OPPOSITION by Provider Plaintiffs to [1666-1] motion to compel arbitration (wc) [Entry date 11/18/02]
11/15/02	1723	OPPOSITION by Provider Plaintiffs to [1659-1] motion to compel arbitration (wc) [Entry date 11/18/02]
11/15/02	1720	SUPPLEMENTAL NOTICE of dismissal of arbitrable claims by Provider Plaintiffs (wc) [Entry date 11/18/02]

DATE	NO.	PROCEEDINGS
11/15/02	1719	MEMORANDUM by Provider Plaintiffs in opposition to [1696-2] motion for involuntary dismissal with prejudice of arbitrable claims, [1664-1] motion to dismiss Second Amended, Consolidated Class Action Complaint, [1662-1] joint motion to dismiss Second Amended Consolidated Class Action Complaint, [1657-1] motion to dismiss claims against United which this Court has already deemed subject to arbitration, as well as those claims against United which this Court may ultimately deem to be subject to arbitration pursuant to United's pending motions to compel arbitration, [1656-1] motion to dismiss Second Amended Consolidated Class Action Complaint and the "Non-Par Claims" and the "Associational Claims" against PacifiCare, [1647-1] motion to dismiss Provider Plaintiffs' Second Ameded Consolidated Class Action Complaint (wc) [Entry date 11/18/02]
11/15/02	1717	MOTION with memorandum in support by Pacificare Health to compel Arbitration (wc) [Entry date 11/18/02]
11/12/02	1710	ORDER denying [1708-1] motion to extend time to file responses to motions to dismiss and motions to compel arbitration (Signed by Judge Federico A. Moreno on 11/12/02) [EOD Date: 11/13/02] (wc) [Entry date 11/13/02]

DATE	NO.	PROCEEDINGS
11/8/02	1708	RENEWED, AGREED MOTION by Provider Plaintiffs to extend time to file responses to motions to dismiss and motions to compel arbitration (wc) [Entry date 11/12/02]
11/6/02	1705	ORDER granting [1272-1] motion for clarification of [711-1] arbitration order and to enjoin arbitration; An injunction is issued preventing Defendants from proceeding with the arbitration proceedings until further notice from this Court (Signed by Judge Federico A. Moreno on 11/6/02) [EOD Date: 11/7/02] (wc) [Entry date 11/07/02]
11/6/02	1704	ORDER granting [1693-1] motion to extend time to file responses to Motions to Dismiss and Motions to Compel arbitration Response to motion reset to 11/15/02 for [1668-1] motion to compel arbitration, reset to 11/15/02 for [1666-1] motion to compel arbitration, reset to 11/15/02 for [1664-1] motion to dismiss Second Amended, Consolidated Class Action Complaint, reset to 11/15/02 for [1662-1] joint motion to dismiss Second Amended Consolidated Class Action Complaint, reset to 11/15/02 for [1659-1] motion to compel arbitration, reset to 11/15/02 for [1657-1] motion to dismiss claims against United which this Court has already deemed subject to arbitration, as well as those claims against United which this Court may ultimately deem to be subject to arbitration pursuant to United's pending motions to compel

DATE	NO.	PROCEEDINGS
		arbitration, reset to 11/15/02 for [1653-1] motion to compel arbitration, reset to 11/15/02 for [1653-2] motion to dismiss claims, reset to 11/15/02 for [1653-3] motion to stay proceedings pending arbitration, reset to 11/15/02 for [1649-1] motion to compel arbitration, reset to 11/15/02 for [1647-1] motion to dismiss Provider Plaintiffs' Second Ameded Consolidated Class Action Complaint (Signed by Judge Federico A. Moreno on 11/6/02) [EOD Date: 11/7/02] (wc) [Entry date 11/07/02]
11/4/02	1697	PROVIDER TRACK MOTION by Provider Plaintiffs to extend time to file responses to Defendants' motions to dismiss, and Plaintiff's motion to compel arbitration (ct) [Entry date 11/05/02
11/1/02	1696	PROVIDER TRACK MOTION by United Healthcare, United Health Group to strike [1637-1] notice, and for involuntary dismissal with prejudice of arbitrable claims (nt) [Entry date 11/04/02]
10/31/02	1693	MOTION by Provider Plaintiffs to extend time to file responses to Motions to Dismiss and Motions to Compel arbitration (wc) [Entry date 11/01/02]
10/23/02	1676	NOTICE of Filing original declaration of Benton Davis in support of Renewed Motion to Compel Arbitration by Humana Health Plan, Humana, Inc. (wc) [Entry date 10/25/02]

DATE	NO.	PROCEEDINGS
10/23/02	1675	DECLARATION of Benton Davis by Humana Health Plan, Humana, Inc. Re: [1668-1] renewed motion to compel arbitration (wc) [Entry date 10/25/02]
10/18/02	1668	RENEWED MOTION with memorandum in support by Humana Health Plan, Humana, Inc. to compel arbitration (wc) [Entry date 10/21/02]
10/18/02	1667	MEMORANDUM by Anthem Health Plans in support of [1666-1] motion to compel arbitration (wc) [Entry date 10/21/02]
10/18/02	1666	MOTION by Anthem Health Plans to compel arbitration (wc) [Entry date 10/21/02]
10/18/02	1663	NOTICE of Renewal of its Motions to Compel Arbitration by Aetna, Inc. (wc) [Entry date 10/21/02]
10/18/02	1661	DECLARATION of Sharon Mos by Wellpoint Health Re: [1659-1] motion to compel arbitration re: Georgia Blue Plaintiffs (wc) [Entry date 10/21/02]
10/18/02	1660	MEMORANDUM of Points and Authorities by Wellpoint Health in support of [1659-1] motion to compel arbitration (wc) [Entry date 10/21/02]
10/18/02	1659	MOTION by Wellpoint Health to compel arbitration (wc) [Entry date 10/21/02]
10/18/02	1657	NOTICE of Renewal of its motions to compel arbitration and to stay proceedings pending arbitration by United Healthcare, United Health Group (wc) [Entry date 10/21/02]

DATE	NO.	PROCEEDINGS
10/18/02	1654	APPENDIX to: [1653-1] motion to compel arbitration, [1653-2] motion to dismiss claims, [1653-3] motion to stay proceedings pending arbitration by Cigna Defendants (wc) [Entry date 10/21/02]
10/18/02	1653	SECOND SUPPLEMENTAL MOTION with memorandum in support by Cigna Defendants to compel arbitration, and to dismiss claims, or to stay proceedings pending arbitration (wc) [Entry date 10/21/02]
10/18/02	1651	NOTICE of Renewal of its Motions to Compel Arbitration by Health Net, Inc. (wc) [Entry date 10/21/02]
10/17/02	1650	PROVIDER TRACK BRIEF by Coventry Health Care in re: second motion to compel arbitration (ct) [Entry date 10/18/02]
10/17/02	1649	PROVIDER TRACK SECOND MOTION by Coventry Health Care to compel arbitration (ct) [Entry date 10/18/02]
10/10/02	1637	NOTICE of DISMISSAL OF ARBITRABLE CLAIMS by Provider Plaintiffs (ct) [Entry date 10/11/02]
9/26/02	1616	ALL TRACK ORDER denying [704-1] motion to certify class action, denying [359-1] motion to certify class action, denying [356-1] motion to certify class action, denying [353-1] motion to certify class action, denying [350-1] motion to certify class action, denying [347-1] motion to certify class action, denying [343-1] motion to certify class action, denying [188-1] motion

DATE	NO.	PROCEEDINGS
		class certification (Signed by Judge Federico A. Moreno on 9/26/02) [EOD Date: 9/26/02] (ct)
9/19/02	1606	REPLY BRIEF by Pacificare Health on [1564-1] motion to compel arbrition as to plaintiffs Boxstein, Breen, Ghalambor, Klay, A. Taleisnik, J. Taleisnik and Wilson (ct) [Entry date 09/20/02]
9/19/02	1605	REPLY MEMORANDUM by Aetna, Inc. in support of [1567-1] motion to compel arbrition, [1567-2] motion to dismiss claims, [1567-3] motion to stay this action (ct) [Entry date 09/20/02
9/19/02	1604	REPLY momorandum by Cigna Defendants in support of [1569-1] motion to compel arbitration, [1569-2] motion to dismiss claim, [1569-3] motion to stay proceedings pending arbitration (ct) [Entry date 09/20/02]
9/17/02	1602	CONSOLIDATED REPLY by Health Net, Inc. in support of [1558-1] motion to compel arbitration of any claims plaintiffs Navid Ghalambor, MD, Susan Hansen, MD, Andres Taleisnik, MD, Taleisnik, MD or Roger Wilson, MD may be asserting against Health Net, Inc., regarding services provided as nonparticipating provider, [1570-2] motion to compel arbitration as to plaintiff Navid Ghalambor (ct) [Entry date 09/18/02]
9/10/02	1595	PROVIDER TRACK ORDER granting [1586-1] motion for Removal and Return of Inadvertently Disclosed Information. Court

DATE	NO.	PROCEEDINGS
		hereby substitutes corrected exhibits to [1168-1] motion to compel arbitration, [1168-2] motion to dismiss claims, [1168-3] motion to stay proceedings pending arbitration [1228-1] motion to compel arbitration, [1228-2] motion to dismiss claims, [1228-3] motion to stay proceedings pending arbitration. Court directs Clerk to destroy copies of uncorrected versions. (See Order for further details.) (Signed by Judge Federico A. Moreno on 09/09/02) [EOD Date: 9/10/02] (nt)
9/9/02	1594	PROVIDER TRACK MEMORANDUM by Provider Plaintiffs in opposition to [1564-1] motion to compel arbrition as to plaintiffs Boxstein, Breen, Ghalambor, Klay, A. Taleisnik, J. Taleisnik and Wilson (nt) [Entry date 09/10/02]
9/9/02	1593	PROVIDER TRACK MEMORANDUM OF LAW IN RESPONSE by Provider Plaintiffs to [1569-1] motion to compel arbitration, [1569-2] motion to dismiss cliam, [1569-3] motion to stay proceedings pending arbitration (nt) [Entry date 09/10/02]
9/9/02	1592	PROVIDER TRACK MEMORANDUM OF LAW IN RESPONSE by Provider Plaintiffs to [1567-1] motion to compel arbrition, [1567-2] motion to dismiss claims, [1567-3] motion to stay this action (nt) [Entry date 09/10/02]

DATE	NO.	PROCEEDINGS
9/9/02	1591	PROVIDER TRACK MEMORANDUM OF LAW IN RESPONSE by Provider Plaintiffs to [1570-1] motion to strike portions of plaintiffs' consolidated amended class action complaint relating to Navid Ghalambor, [1570-2] motion to compel arbitration as to plaintiff Navid Ghalambor (nt) [Entry date 09/10/02]
9/9/02	1590	PROVIDER TRACK CONSOLIDATED MEMORANDUM OF LAW IN RESPONSE by Provider Plaintiffs to [1558-1] motion to compel arbitration of any claims plaintiffs Navid Ghalambor, MD, Susan Hansen, MD, Andres Taleisnik, MD, Julio Taleisnik, MD or Roger Wilson, MD may be asscrting against Health Net, Inc., regarding services provided as nonparticipating provider. [1557-1] motion to compel arbitration of the claims asserted by Navid Ghalambor, MD as a participating provider (nt) [Entry date 09/10/02]
9/9/02	1588	PROVIDER TRACK MOTION by Edgar Borrero, Zachery Rosenberg for clarification that they are not required to respond to motions to compel arbitration, or, alternatively, to extend time to respond to such motions (nt) [Entry date 09/10/02]
9/4/02	1585	ORDER granting [1551-1] motion for Hearing on [1272-1] motion for clarification of [711-1] arbitration order granting [1577-1] motion for Hearing on [1272-1] motion for clarification of [711-1] arbitration order Motion hearing before Judge Federico A.

DATE	NO.	PROCEEDINGS
		Moreno set for 10:00 10/8/02 for [1272-1] motion for clarification of [711-1] arbitration order (Signed by Judge Federico A. Moreno on 8/30/02) [EOD Date: 9/5/02] (ct) [Entry date 09/05/02]
8/30/02	1579	ORDER granting [1578-1] motion to substitute redacted copies of attachment to its supplemental motion to compel arbitration, dismiss claims and stay this action (Signed by Judge Federico A. Moreno on 8/30/02) [EOD Date: 9/3/02] (cj) [Entry date 09/03/02]
8/28/02	1578	MOTION by Aetna, Inc. to substitute redacted copies of attachment to its supplemental motion to compel arbitration, dismiss claims and stay this action (ct) [Entry date 08/29/02]
8/22/02	1577	MOTION by United Healthcare for Hearing on [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 08/23/02]
8/20/02	1575	Provider Track Declaration of Katrina Pelto by Pacificare Health in support of [1564-1] motion to compel arbrition as to plaintiffs Boxstein, Breen, Ghalambor, Klay, A. Taleisnik, J. Taleisnik and Wilson (ct) [Entry date 08/21/02]
8/20/02	1574	PROVIDER TRACK NOTICE of filing original declaration in support of defendant Pacificare Health Systems, Inc., supplemental motion to compel arbitration as to plaintiffs Boxstein, Breen, Ghalambor, A.

DATE	NO.	PROCEEDINGS
		Teleisnik, J. Taleisnik and Wilson by Pacificare Health (ct) [Entry date 08/21/02] [Edit date 08/21/02]
8/16/02	1573	APPENDIX to: [1569-1] motion to compel arbitration, [1569-2] motion to dismiss cliam, [1569-3] motion to stay proceedings pending arbitration by Cigna Corporation (ct) [Entry date 08/19/02]
8/16/02	1572	MEMORANDUM of points and authority by Aetna, Inc. in support of [1567-1] motion to compel arbrition, [1567-2] motion to dismiss claims, [1567-3] motion to stay this action (ct) [Entry date 08/19/02]
8/16/02	1571	MOTION by United Healthcare NJ, United Healthcare, United Health Group for leave to file additional motions to compel arbitration based on discovery (ct) [Entry date 08/19/02]
8/16/02	1571	PROVIDER TRACK JOINDER in motion to compel arbitration by co-defendants by United Healthcare, United Health Group, United Healthcare NJ (ct) [Entry date 08/19/02]
8/16/02	1570	MOTION with memorandum in support by United Healthcare to strike portions of plaintiffs' consolidated amended class action complaint relating to Navid Ghalambor, or to compel arbitration as to plaintiff Navid Ghalambor (ct) [Entry date 08/19/02]

DATE	NO.	PROCEEDINGS
8/16/02	1569	PROVIDER TRACK CORRECTED AND SUPPLEMENTAL MOTION with memorandum in support by Cigna Corporation to compel arbitration, and to dismiss cliam, or to stay proceedings pending arbitration (ct) [Entry date 08/19/02]
8/16/02	1568	MOTION by Aetna, Inc. for leave to file additional motions to compel arbitration based on discovery (ct) [Entry date 08/19/02]
8/16/02	1568	JOINDER in motions to compel arbrition of co-defendants by Aetna, Inc. (ct) [Entry date 08/19/02]
8/16/02	1567	PROVIDER TRACK SUPPLEMENTAL MOTION by Aetna, Inc. to compel arbrition, to dismiss claims, and to stay this action (ct) [Entry date 08/19/02]
8/16/02	1566	NOTICE of filing declaration of Katrina Pelto and Valerie Blomquist in support of defendant PacifiCare supplemental motion to compel arbitration by Pacificare Health (ct) [Entry date 08/19/02]
8/16/02	1565	PROVIDER TRACK MOTION by Pacificare Health for leave to file additional motions to compel arbitration based on discovery (ct) [Entry date 08/19/02]
8/16/02	1565	Pacificare Health joinder in motion to compel arbitration of co-defendants (ct) [Entry date 08/19/02]

DATE	NO.	PROCEEDINGS
8/16/02	1564	PROVIDER TRACK MOTION with memorandum in support by Pacificare Health to compel arbrition as to plaintiffs Boxstein, Breen, Ghalambor, Klay, A. Taleisnik, J. Taleisnik and Wilson (ct) [Entry date 08/19/02]
8/16/02	1563	PROVIDER TRACK MOTION by Prudential Insurance to extend time to file motion to compel arbitation (ct) [Entry date 08/19/02]
8/16/02	1562	PROVIDER TRACK MOTION with memorandum in support by United Healthcare to compel plaintiff Zachery Rosenberg to arbitrate his claims , and to stay proceedings pending arbitration (ct) [Entry date 08/19/02] [Edit date 08/19/02]
8/16/02	1561	PROVIDER TRACK MOTION with memorandum in support by United Healthcare, United Healthcare NJ to compel plaintiff John Sutter to arbitrate his cliams, and to stay proceedings pending arbitration (ct) [Entry date 08/19/02] [Edit date 08/19/02]
8/16/02	1560	PROVIDER TRACK MOTION with memorandum in support by United Healthcare, United Health Group to compel Edgar Borrero to arbitrate his cliams, and to stay proceedings pending arbitration (ct) [Entry date 08/19/02] [Edit date 08/19/02]

DATE	NO.	PROCEEDINGS
8/16/02	1559	APPENDIX to: [1557-1] motion to compel arbitration of the claims asserted by Navid Ghalambor, MD as a participating provider by Health Net, Inc. (ct) [Entry date 08/19/02]
8/16/02	1558	PROVIDER TRACK MOTION with memorandum in support by Health Net, Inc. to compel arbitration of any claims plaintiffs Navid Ghalambor, MD, Susan Hansen, MD, Andres Taleisnik, MD, Julio Taleisnik, MD or Roger Wilson, MD may be asserting against Health Net, Inc., regarding services provided as nonparticipating provider (ct) [Entry date 08/19/02] [Edit date 08/19/02]
8/16/02	1557	PROVIDER TRACK MOTION with memorandum in support by Health Net, Inc. to compel arbitration of the claims asserted by Navid Ghalambor, MD as a participating provider (ct) [Entry date 08/19/02]
8/12/02	1551	MOTION by Provider Plaintiffs for Hearing on [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 08/13/02
8/12/02	1550	PROVIDER TRACK REPLY by Provider Plaintiffs to response to [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 08/13/02] [Edit date 08/13/02]

DATE	NO.	PROCEEDINGS
8/12/02	1549	ORDER granting [1547-1] motion for a further 1 day extension of time to file a consolidated reply to all responses to provider plaintiffs' motion for clarification and to enjoin arbitration (Signed by Judge Federico A. Moreno on 8/12/02) [EOD Date: 8/13/02] (ct) [Entry date 08/13/02]
8/9/02	1547	PROVIDER TRACK MOTION by Provider Plaintiffs for a further 1 day extension of time to file a consolidated reply to all responses to provider plaintiffs' motion for clarification and to enjoin arbitration (ct) [Entry date 08/12/02]
8/7/02	1545	ORDER granting [1543-1] motion to a 4-Day extension of time to file reply to Pacificare Health Systems, Inc.'s response to motion for clarification and to enjoin arbitration by Friday, August 9, 2002. (Signed by Judge Federico A. Moreno on 8/7/02) [EOD Date: 8/8/02] (ct) [Entry date 08/08/02]
8/5/02	1543	PROVIDER TRACK MOTION by Provider Plaintiffs to a 4-Day extension of time to file reply to Pacificare Health Systems, Inc.'s response to motion for clarification and to enjoin arbitration (ct) [Entry date 08/06/02]
8/1/02	1538	MEMORANDUM by United Healthcare, United Health Group in opposition to [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 08/02/02]

DATE	NO.	PROCEEDINGS
8/1/02	1537	NOTICE of filing "corrected" memorandum of law in opposition to plaintiffs' motion for clarification of December 11, 2000 arbitration order and to enjoin arbitration of non-arbitrable claims by United Healthcare, United Health Group (ct) [Entry date 08/02/02]
7/31/02	1535	MEMORANDUM by Prudential Insurance in opposition to [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 08/01/02]
7/30/02	1533	MEMORANDUM OF LAW by United Healthcare, United Health Group in opposition to [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 07/31/02]
7/30/02	1532	PROVIDER TRACK RESPONSE by Pacificare Health to [1272-1] motion for clarification of [711-1] arbitration order (ct) [Entry date 07/31/02] [Edit date 07/31/02]
6/29/01	1306	PROVIDER TRACK ORDER denying [1293-1] motion to extend time to file response to Coventry's motion to dismiss and to compel arbitration and to reply to its brief opposing class certification (Signed by Judge Federico A. Moreno on 06/29/01) [EOD Date: 6/29/01] (nt)
6/26/01	1298	PROVIDER TRACK DECLARATION of Cathy N. Batteer by Pacificare Health Re: [1296-1] motion to compel arbitration as to Plaintiffs Ghalambor and Hansen (nt) [Entry date 06/27/01

DATE	NO.	PROCEEDINGS
6/26/01	1298	PROVIDER TRACK NOTICE of Filing Original Declaration of Cathy N. Batteer by Pacificare Health (nt) [Entry date 06/27/01]
6/26/01	1297	PROVIDER TRACK DECLARATION of Guillermo Cabrera by Pacificare Health Re: [1296-1] motion to compel arbitration as to Plaintiffs Ghalambor and Hansen (nt) [Entry date 06/27/01]
6/26/01	1297	PROVIDER TRACK NOTICE of Filing Original Declaration of Guillermo Cabrera by Pacificare Health (nt) [Entry date 06/27/01]
6/26/01	1296	PROVIDER TRACK MOTION with memorandum in support by Pacificare Health to compel arbitration as to Plaintiffs Ghalambor and Hansen (nt) [Entry date 06/27/01]
6/25/01	1293	PROVIDER TRACK MOTION by Provider Plaintiffs to extend time to file response to Coventry's motion to dismiss and to compel arbitration and to reply to its brief opposing class certification (nt) [Entry date 06/26/01]
6/12/01	1272	PROVIDER TRACK MOTION with memorandum in support by Provider Plaintiffs for clarification of [711-1] arbitration order (nt) [Entry date 06/15/01]
6/12/01	1264	PROVIDER TRACK AGREED ORDER on Cigna Defendants' Agreed Motion for Extension of Time to Serve a Reply Supporting their Amended Motion to Compel Arbitration and to Dismiss Claims or Stay Proceedings Pending Arbitration. Cigna

DATE	NO.	PROCEEDINGS
		Defendants' response to the Amended Complaint is extended through June 8, 2001. (Signed by Judge Federico A. Moreno on 06/11/01) CCAP [EOD Date: 6/13/01] (nt) [Entry date 06/13/01]
6/8/01	1271	PROVIDER TRACK REPLY MEMORANDUM by Wellpoint Health to response to [1158-1] motion to compel arbitration (nt) [Entry date 06/13/01]
6/8/01	1270	PROVIDER TRACK REPLY by Cigna Corporation, Cigna Health to response to [1228-1] motion to compel arbitration, [1228-2] motion to dismiss claims, [1228-3] motion to stay proceedings pending arbitratio, [1228-4] amended motion (nt) [Entry date 06/13/01]
6/8/01	1269	PROVIDER TRACK AGREED MOTION by Cigna Corporation, Cigna Health to extend time to serve reply supporting amended motion to compel arbitration and to dismiss claims or stay proceedings pending arbitration (nt) [Entry date 06/13/01
6/8/01	1268	PROVIDER TRACK REPLY by Aetna, Inc., Aetna-US to response to [1169-1] motion to compel arbitration, [1169-2] motion to dismiss claims asserted by certain newly-added plaintiffs, [1169-3] motion to stay this action (nt) [Entry date 06/13/01]

DATE	NO.	PROCEEDINGS
6/8/01	1267	PROVIDER TRACK REPLY by Pacificare Health to response to [1193-1] motion to compel arbitration of conspiracy and aiding-and-abetting claims based on their arbitration commitments with other defendants (nt) [Entry date 06/13/01]
6/8/01	1266	REPLY by Health Net, Inc. in support of its [1165-1] motion to compel arbitration (nt) [Entry date 06/13/01]
6/8/01	1254	PROVIDER TRACK APPENDIX in support of: [1253-1] response reply by United Healthcare, United Health Group (nt) [Entry date 06/12/01]
6/8/01	1253	PROVIDER TRACK REPLY by United Healthcare, United Health Group to response to [1182-1] motion to compel plaintiffs to arbitrate their claims (nt) [Entry date 06/12/01]
6/8/01	1250	PROVIDER TRACK BRIEF by Coventry Health Care in support of [1249-1] motion to compel arbitration (nt) [Entry date 06/11/01]
6/8/01	1249	PROVIDER TRACK MOTION by Coventry Health Care to compel arbitration (nt) [Entry date 06/11/01]
6/7/01	1245	PROVIDER TRACK REPLY MEMORANDUM by Prudential Insurance to response to [1137-1] motion to compel to arbitrate their claims (nt) [Entry date 06/08/01]
6/5/01	1244	PROVIDER TRACK ARBITRATION STATUS REPORT by Provider Plaintiffs (nt) [Entry date 06/06/01]

DATE	NO.	PROCEEDINGS
5/31/01	1239	PROVIDER TRACK ARBITRATION STATUS REPORT by Prudential Insurance (nt) [Entry date 06/01/01]
5/31/01	1238	PROVIDER TRACK ARBITRATION STATUS REPORT by Health Net, Inc. (nt) [Entry date 06/01/01]
5/31/01	1237	PROVIDER TRACK ARBITRATION STATUS REPORT by Cigna Corporation, Cigna Health (nt) [Entry date 06/01/01]
5/31/01	1235	PROVIDER TRACK RESPONSE to [1199-1] Order to Show Cause Related to Dr. Kelly by Provider Plaintiffs (nt) [Entry date 06/01/01]
5/31/01	1234	PROVIDER TRACK RESPONSE by Provider Plaintiffs to [1182-1] motion to compel plaintiffs to arbitrate their claims, [1137-1] to compel to arbitrate their claims, [1168-1] motion to compel arbitration, [1165-1] motion to compel arbitration, [1158-1] motion to compel arbitration (nt) [Entry date 06/01/01]
5/31/01	1233	PROVIDER TRACK RESPONSE by Provider Plaintiffs to [1169-1] motion to compel arbitration (nt) [Entry date 06/01/01]
5/31/01	1232	PROVIDER TRACK RESPONSE by Provider Plaintiffs to [1171-1] motion to compel arbitration (nt) [Entry date 06/01/01]
5/31/01	1230	PROVIDER TRACK ARBITRATION STATUS REPORT by Wellpoint Health (nt)

DATE	NO.	PROCEEDINGS
5/30/01	1229	PROVIDER TRACK ARBITRATION STATUS REPORT by United Healthcare, United Health Group (nt) [Entry date 05/31/01]
5/29/01	1228	AMENDED MOTION by Cigna Corporation, Cigna Health to compel arbitration, and to dismiss claims, or to stay proceedings pending arbitratio amending [1168-1] motion to compel arbitration, [1168-2] motion to dismiss claims, [1168-3] motion to stay proceedings pending arbitration (nt) [Entry date 05/30/01]
5/21/01	1217	PROVIDER TRACK ORDER granting [1214-1] motion to extend time to file consolidated response to motions to dismiss, terminating [1213-1] motion to extend time to file consolidated to motions to dismiss Response to motions to dismiss reset to 6/15/01 for [1174-1] joint motion to dismiss consolidated amended class action complaint, reset to 6/15/01 for [1172-1] to dismiss RICO, and claims, reset to 6/15/01 for [1169-2] motion to dismiss claims asserted by certain newly-added plaintiffs, reset to 6/15/01 for [1168-2] motion to dismiss claims, reset to 6/15/01 for [1167-1] motion to dismiss Provider Plaintiffs' Consolidated Amended Class Action Complaint (See Order for further details.) (Signed by Judge Federico A. Moreno on CCAP [EOD Date: 5/22/01] (nt) [Entry date 05/22/01]

DATE	NO.	PROCEEDINGS
5/17/01	1215	PROVIDER TRACK ARBITRATION STATUS REPORT by Pacificare Health (nt) [Entry date 05/21/01]
5/14/01	1209	PROVIDER TRACK ORDER granting [1206-1] motion to extend time to file consolidated response to motions to compel arbitration Reply to Response to Motion reset to 5/30/01 for [1193-1] motion to compel arbitration of conspiracy and aiding-and-abetting claims based on their arbitration commitments with other defendants, reset to 5/30/01 for [1182-1] motion to compel plaintiffs to arbitrate their claims, reset to 5/30/01 for [1171-1] motion to compel arbitration, reset to 5/30/01 for [1169-1] motion to compel arbitration, reset to 5/30/01 for [1168-1] motion to compel arbitration, reset to 5/30/01 for [1165-1] motion to compel arbitration, reset to 5/30/01 for [1158-1] motion to compel arbitration, reset to 05/30/01 for [1137-1] motion to compel to arbitrate their claims, reset to 5/30/01 for [1130-1] motion to compel arbitration as to newly added plaintiffs, reset to 5/30/01 for [985-1] motion to compel plaintiffs to arbitrate their claims, reset to 5/30/01 for [991-1] motion to compel arbitration (Signed by Judge Federico A. Moreno on 05/11/01) CCAP [EOD Date: 5/15/01] (nt) [Entry date 05/15/01]

DATE	NO.	PROCEEDINGS
5/10/01	1207	PROVIDER TRACK MOTION with memorandum in support by Health Net, Inc. for reconsideration of [1142-1] arbitration order (nt) [Entry date 05/11/01]
5/10/01	1206	PROVIDER TRACK MOTION by Provider Plaintiffs to extend time to file consolidated response to motions to compel arbitration (nt) [Entry date 05/11/01]
5/9/01	1202	PROVIDER TRACK NOTICE Regarding Arbitration by Pacificare Health (nt) [Entry date 05/10/01]
5/9/01	1201	PROVIDER TRACK ORDER Requiring Arbitration Reports Status report due on 5/31/01 (Signed by Judge Federico A. Moreno on 5/8/01) CCAP [EOD Date: 5/10/01] (nt) [Entry date 05/10/01]
5/4/01	1199	PROVIDER TRACK ORDER OF REMAND AND ORDER TO SHOW CAUSE DIRECTED TO DR. KELLY why the Court should not compel arbitration of isviolation of state prompt pay statute claim. Response to Order to Show Cause due 5/29/01. United may file a response no later than 06/06/01. (See Order for further details.) (Signed by Judge Federico A. Moreno on 5/4/01) CCAP [EOD Date: 5/10/01] (nt) [Entry date 05/10/01]
5/4/01	1194	PROVIDER TRACK NOTICE of Filing Declaration of Guillermo Cabrera by Pacificare Health (nt) [Entry date 05/08/01]

DATE	NO.	PROCEEDINGS
5/4/01	1193	PROVIDER TRACK MOTION with memorandum in support by Pacificare Health to compel arbitration of conspiracy and aiding-and-abetting claims based on their arbitration commitments with other defendants (nt) [Entry date 05/08/01]
5/4/01	1192	PROVIDER TRACK SUPPLEMENTAL DECLARATION of Lisa Duran by Wellpoint Health Re: [1158-1] motion to compel arbitration (nt) [Entry date 05/08/01]
5/4/01	1190	PROVIDER TRACK ORDER granting motion for a two-day extension of time to file motion to compel arbitration; motion to compel is due 05/02/01. (Signed by Judge Federico A. Moreno on 5/1/01) CCAP [EOD Date: 5/8/01] (nt) [Entry date 05/08/01]
5/2/01	1184	PROVIDER TRACK DECLARATION of Marie Chen by Health Net, Inc. Re: [1165-1] motion to compel arbitration (nt) [Entry date 05/03/01]
5/2/01	1182	MOTION with memorandum in support by United Healthcare, United Health Group to compel plaintiffs to arbitrate their claims, and to stay proceedings pending arbitration (nt) [Entry date 05/03/01]
4/30/01	1177	PROVIDER TRACK NOTICE of Joinder and Joinder of [1137-1] motion to compel to arbitrate their claims by Aetna, Inc., Aetna-US (nt) [Entry date 05/02/01]

DATE	NO.	PROCEEDINGS
4/30/01	1171	PROVIDER TRACK MOTION with memorandum in support by Humana, Inc., Humana Health Plan to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1170	PROVIDER TRACK MEMORANDUM of Points and Authorities by Aetna, Inc., Aetna-US in support of [1169-1] motion to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1169	PROVIDER TRACK MOTION by Aetna, Inc., Aetna-US to compel arbitration, to dismiss claims asserted by certain newly-added plaintiffs, and to stay this action (nt) [Entry date 05/01/01]
4/30/01	1168	PROVIDER TRACK MOTION by Cigna Corporation, Cigna Health, Cigna Health-care to compel arbitration, and to dismiss claims, or to stay proceedings pending arbitration (nt) [Entry date 05/01/01]
4/30/01	1166	PROVIDER TRACK APPENDIX to: [1165-1] motion to compel arbitration by Health Net, Inc. (nt) [Entry date 05/01/01]
4/30/01	1165	PROVIDER TRACK MOTION with memorandum in support by Health Net, Inc. to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1164	PROVIDER TRACK DECLARATION of Lisa Duran by Wellpoint Health Re: [1158-1] motion to compel arbitration (nt) [Entry date 05/01/01]

DATE	NO.	PROCEEDINGS
4/30/01	1163	PROVIDER TRACK DECLARATION of Scott M. Garringer by Wellpoint Health Re: [1158-1] motion to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1162	PROVIDER TRACK DECLARATION of Deborah Nalbandian by Wellpoint Health Re: [1158-1] motion to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1161	PROVIDER TRACK DECLARATION of Joe Garcia by Wellpoint Health Re: [1158-1] motion to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1160	PROVIDER TRACK DECLARATION of Sue Sheridan by Wellpoint Health Re: [1158-1] motion to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1159	PROVIDER TRACK MEMORANDUM by Wellpoint Health in support of [1158-1] motion to compel arbitration (nt) [Entry date 05/01/01]
4/30/01	1158	PROVIDER TRACK MOTION by Well-point Health to compel arbitration (nt) [Entry date 05/01/01]
4/27/01	1138	PROVIDER TRACK MEMORANDUM by Prudential Insurance in support of [1137-1] motion to compel to arbitrate their claims (nt) [Entry date 04/30/01]
4/27/01	1137	PROVIDER TRACK MOTION by Pru-dential Insurance to compel to arbitrate their claims (nt) [Entry date 04/30/01]

DATE	NO.	PROCEEDINGS
4/26/01	1142	PROVIDER TRACK ORDER granting in part [888-1] motion to compel arbitration, and order modifying prior arbitration order concerning Foundation's motion to compel. (See Order for further details.) (Signed by Judge Federico A. Moreno on 4/25/01) CCAP [EOD Date: 5/1/01] (nt) [Entry date 05/01/01]
4/26/01	1136	PROVIDER TRACK DECLARATION of Cathy N. Batteer by Pacificare Health Re: [1130-1] motion to compel arbitration as to newly added plaintiffs (nt) [Entry date 04/27/01]
4/26/01	1135	PROVIDER TRACK NOTICE of Filing Declaration of Cathy N. Batteer by Pacificare Health (nt) [Entry date 04/27/01]
4/26/01	1134	PROVIDER TRACK DECLARATION of Austin Pittman by Pacificare Health Re: [1130-1] motion to compel arbitration as to newly added plaintiffs (nt) [Entry date 04/27/01]
4/26/01	1133	PROVIDER TRACK NOTICE of Filing Declaration of Austin Pittman by Pacificare Health (nt) [Entry date 04/27/01]
4/26/01	1132	PROVIDER TRACK DECLARATION of Scott Keim by Pacificare Health Re: [1130-1] motion to compel arbitration as to newly added plaintiffs (nt) [Entry date 04/27/01]
4/26/01	1131	PROVIDER TRACK NOTICE of Filing Declaration of Scott Keim by Pacificare Health (nt) [Entry date 04/27/01]

DATE	NO.	PROCEEDINGS
4/26/01	1130	PROVIDER TRACK MOTION by Pacificare Health to compel arbitration as to newly added plaintiffs (nt) [Entry date 04/27/01]
4/25/01	1076	PROVIDER TRACK NOTICE of Filing Redacted Substitute for Docket Entry #258: Declarations of Kevin Roddy and Cathy N. Batteer in Support of Motion to Compel Arbitration and to Dismiss All Claims by Pacificare Health, Pacificare, Inc. (nt) [Entry date 04/26/01]
4/25/01	1075	PROVIDER TRACK NOTICE of Filing Redacted Substitute for Docket Entries #889 and #899 to #901: Declarations of Scott Keim, Austin Pitman, Pam Leal, Leeba Lesin and James Fazio by Pacificare Health, Pacificare, Inc. (nt) [Entry date 04/26/01]
4/25/01	1074	PROVIDER TRACK NOTICE of Filing Redacted Substitute for Docket Entries #437 & #410: Declaration of Cathy N. Batteer in Support of Motion to Compel Arbitration by Pacificare Health, Pacificare, Inc. (nt) [Entry date 04/26/01]
4/6/01	1032	PROVIDER TRACK REPLY MEMORANDUM by Prudential Insurance in support of [985-1] motion to compel plaintiffs to arbitrate their claims (nt) [Entry date 04/11/01]
4/6/01	1027	PROVIDER TRACK REPLY by United of Florida to memorandum of law in opposition to motion to compel arbitration and for a stay of proceedings (nt) [Entry date 04/09/01]

DATE	NO.	PROCEEDINGS
4/6/01	1026	PROVIDER TRACK REPLY MEMORANDUM by United of Georgia, United Health Group in support of their motion to compel arbitration and for a stay of proceedings (nt) [Entry date 04/09/01]
4/5/01	1024	PROVIDER TRACK REPLY by Coventry of Georgia, Principal Health to supplemental brief in opposition to motions to compel arbitration and stay proceedings (nt) [Entry date 04/06/01] [Edit date 04/11/01]
4/3/01	1023	PROVIDER TRACK ORDER denying [1016-1] motion to stay proceedings pending appeal of court's order of 12/11/00 granting in part and denying in part various defendant's motions to compel arbitration and motion to stay proceedings pending arbitration (Signed by Judge Federico A. Moreno on 4/2/01) CCAP [EOD Date: 4/6/01] (nt) [Entry date 04/06/01]
4/2/01	1021	PROVIDER TRACK ORDER denying [1019-1] motion to stay the Provider Track proceedings against Health Net, pending appeal of 12/11/00 order and outcome of the provider arbitrations (Signed by Judge Federico A. Moreno on 04/02/01) CCAP [EOD Date: 4/3/01] (nt) [Entry date 04/03/01]
3/30/01	1020	PROVIDER TRACK MEMORANDUM by H. Robert Harrison in opposition to motions to compel arbitration and stay proceedings (nt) [Entry date 04/03/01]

DATE	NO.	PROCEEDINGS
3/29/01	1019	PROVIDER TRACK MOTION by Health Net, Inc. to stay the Provider Track proceedings against Health Net, pending appeal of 12/11/00 order and outcome of the provider arbitrations (nt) [Entry date 04/03/01]
3/29/01	1017	PROVIDER TRACK - MEMORANDUM by William M. Blackshear Jr. in opposition to defendant's supplemental memorandum of law in support of defendant's motion to compel arbitration and for stay of proceedings (mg) [Entry date 03/30/01]
3/29/01	1016	PROVIDER TRACK—MOTION with memorandum in support by United Healthcare, United Health Group to stay proceedings pending appeal of court's order of 12/11/00 granting in part and denying in part various defendant's motions to compel arbitration and motion to stay proceedings pending arbitration (mg) [Entry date 03/30/01]
3/26/01	1015	PROVIDER TRACK—AMENDED COMPLAINT by Provider Plaintiffs , (Answer due 4/5/01 for Aetna of California, for United of Florida, for Prudential Georgia, for Prudential of CA, for Prudential of CT, for Prudential New York, for Prudential Health, for Richard L. Huber, for David Jones, for Edward H. Hanway, Aetna of Georgia, for United of Georgia, for Principal Health, for Coventry Health Care, for Wellpoint Health, for Pacificare, Inc., for Cigna Healthcare, for Humana Insurance,

DATE	NO.	PROCEEDINGS
		for Humana, Inc., for Connecticut General, for Cigna Health, for Cigna Corporation, for Unnamed Members, for Richard L. Huber, for Aetna-US, for Aetna, Inc., for Humana Health Plan, for United Health Group, for United Healthcare, for Prudential Insurance, for Pacificare for Foundation Health) amending complaint. to be consistent with court's order of 12/11/00 (order granting in part and denying in part various defendant's motion to compel arbitration) (mg) [Entry date 03/27/01]
3/9/01	989	PROVIDER TRACK SUPPLEMENTAL MEMORANDUM of law by United Healthcare, United of Georgia in support of motion to compel arbitration and for a stay of proceedings (nt) [Entry date 03/12/01]
3/9/01	988	PROVIDER TRACK SUPPLEMENTAL MEMORANDUM of law by United of Florida in support of motion to compel and for a stay of proceedings (nt) [Entry date 03/12/01]
3/9/01	986	PROVIDER TRACK MEMORANDUM by Prudential Insurance in support of [985-1] motion to compel plaintiffs to arbitrate their claims (nt)
3/9/01	985	MOTION by Prudential Insurance to compel plaintiffs to arbitrate their claims (nt)
3/5/01	975	ALL CASES OMNIBUS ORDER #5 Order Setting Supplemental Oral Argument on Motions to Compel, Setting Briefing Schedule for Tag-Along Briefing of Motions to

DATE	NO.	PROCEEDINGS
		Compel Arbitration, Staying Tag-Along Briefing of Motions to Dismiss and Amending Complaints, Canceling Telephone Status Conference with Milberg Weiss, Requiring Defendants to Designate One Attorney Each for Service of Motions Motion hearing on 02/27/01 8:45 before Judge Federico A. Moreno on [925-1] motion to compel and [948-1] motion to compel and for sanctions, set motions to compel arbitration filing deadline for 3/9/01, tag-along litigants are stayed from filing motions to dismiss and amending complaints until after ruling on lead motions to dismiss, set supplemental telephone tag-along status conference for 10:30 2/26/01 before Judge Federico A. Moreno (See Order for further details.) (Signed by Judge Federico A. Moreno on 2/28/01) CCAP [EOD Date: 3/6/01] (nt) [Entry date 03/06/01]
3/2/01	973	REPLY Memorandum by Pacificare Health, Pacificare, Inc. to response to [888-1] motion to compel arbitration (nt) [Entry date 03/05/01]
3/2/01	972	PROVIDER TRACK REPLY by Pacificare Health, Pacificare, Inc. to response to [888-1] motion to compel arbitration (nt) [Entry date 03/05/01]
3/2/01	971	PROVIDER TRACK ORDER Granting in Part Without Prejudice Motions to Dismiss Provider Track Complaint granting in part [264-1] motion to dismiss amended complaint, granting in part [307-1] motion to

DATE	NO.	PROCEEDINGS
		dismiss amended complaint class action, granting in part [310-1] motion to dismiss provider track amended complaint, granting in part [312-1] motion to dismiss ali claims pursuant to Fed. R. Civ. Proc. 9(B) and 12(B)(6), granting in part [317-1] motion to dismiss the complaint, granting in part [393-1] motion to dismiss provider track amended complaint granting in part [319-1] motion to dismiss amended complaint, granting in part [393-1] motion to dismiss provider track amended complaint (Signed by Judge Federico A. Moreno on 03/02/01) CCAP [EOD Date: 3/2/01] (nt)
2/27/01	965	PROVIDER TRACK REPLY by Pacificare Health, Pacificare, Inc. to response to [888-1] motion to compel arbitration (nt) [Entry date 02/28/01]
2/22/01	962	PROVIDER TRACK RESPONSE by Provider Plaintiffs in opposition to [888-1] motion to compel arbitration (cj) [Entry date 02/23/01]
2/20/01	953	OPPOSITION by Provider Plaintiffs to [888-1] motion to compel arbitration (nt) [Entry date 02/21/01]
2/2/01	918	PROVIDER TRACK ORDER granting [914-1] motion to extend time to file reply to contingent supplemental motion to compel arbitration Response to motion reset to 2/20/01 for [888-1] motion to compel arbitration (Signed by Judge Federico A. Moreno on 2/2/01) CCAP [EOD Date: 2/7/01] (nt) [Entry date 02/07/01]

DATE	NO.	PROCEEDINGS
2/1/01	914	PROVIDER TRACK MOTION by Provider Plaintiffs to extend time to file reply to contingent supplemental motion to compel arbitration (nt) [Entry date 02/02/01]
1/26/01	888	PROVIDER TRACK CONTINGENT SUPPLEMENTAL MOTION with memorandum in support by Pacificare Health, Pacificare, Inc. to compel arbitration (nt) [Entry date 01/29/01]
1/24/01	875	ORDER Setting Tag-Along Status Conference, and Granting Plaintiffs' Motions for Leave and Direction; granting [851-1] motion for status conference regarding recently transferred cases, leave to supplement record and file additional briefs on arbitration issue, and direction regarding class certification issue set status conference for 10:30 2/21/01 before Judge Federico A. Moreno (Signed by Judge Federico A. Moreno on 01/23/01) CCAP [EOD Date: 1/25/01] (nt) [Entry date 01/25/01
1/22/01	863	ORDER denying in part [752-1] motion for reconsideration of [711-1] order, denying in part [752-2] motion for clarification of [711-1] order it relates to her claims (Signed by Judge Federico A. Moreno on 1/18/01) CCAP [EOD Date: 1/23/01] (nt) [Entry date 01/23/01]
1/17/01	851	PROVIDER TRACK MOTIONS by Provider Plaintiffs for status conference regarding recently transferred cases, leave to supplement record and file additional briefs

DATE	NO.	PROCEEDINGS
		on arbitration issue, and direction regarding class certification issue (cj) [Entry date 01/19/01]
12/22/00	762	ORDER granting Provider Plaintiff's [755-1] motion to extend time (60)day to respond to defendant's Pacificare and Blue Cross' renewed motions to compel arbitration and dismiss all claims (in Klay and CMA) Response to motion reset to 2/22/01 for [757-1] motion to compel to immediately produce an adequate 30(b) witness for deposition here in Miami, (2) complete documents responsive to plaintiff's document requests, and for sanctions (Signed by Judge Federico A. Moreno on 12/21/00) CCAP [EOD Date: 12/27/00] (cj) [Entry date 12/27/00]
12/21/00	755	PROVIDER PLAINTIFFS' MOTION by Provider Plaintiffs to extend time (60)day to respond to defendant's Pacificare and Blue Cross' renewed motions to compel arbitration and dismiss all claims (in Klay and CMA) (cj) [Entry date 12/22/00]
12/11/00	712	PROVIDER TRACK NOTICE of filing original signature page of Declaration of Suzanne K. Fogel in support of Notice of Removal of Motion to Dismiss or, in the alternative of motion to compel arbitration (attached) by Blue Cross of CA (cj) [Entry date 12/12/00]
12/11/00	711	ALL CASES ORDER Granting in Part and Denying in Part Various Defendants' Motions to Compel Arbitration; granting

DATE	NO.	PROCEEDINGS
		[76-1] motion to compel arbitration, terminating [76-2] motion to dismiss all claims granting in part, denying in part [257-1] motion to compel arbitration, terminating [257-2] motion to dismiss all claims granting part, denying in part [313-1] motion to compel arbitration terminating [314-1] motion to dismiss complaint, granting part, denying in part [314-2] motion to compel arbitration granting in part, denying in part [319-1] motion to dismiss amended complaint granting in part, denying in part [323-1] motion to compel arbitration granting in part, denying in part [457-1] motion to compel arbitration (Signed by Judge Federico A. Moreno on 12/11/00) CCAP [EOD Date: 12/12/00] (nt) [Entry date 12/12/00]
12/8/00	709	NOTICE of Renewal of Motion to Dismiss or, in the alternative, Incorporation of Motion to Compel Arbitration by Blue Cross of CA (nt) [Entry date 12/11/00]
12/7/00	707	PROVIDER TRACK RESPONSE by Provider Plaintiffs to supplemental memoranda and documents re: arbitration issues (nt) [Entry date 12/08/00]
12/1/00	694	PROVIDER TRACK REPLY BRIEF in Response to Issues Presented to the Court at the 10/26/00 Hearing by Pacificare Health, Pacificare, Inc. (nt) [Entry date 12/04/00]
12/1/00	693	PROVIDER TRACK NOTICE of Renewal of Motions by Pacificare Health, Pacificare, Inc. (nt) [Entry date 12/04/00]

DATE	NO.	PROCEEDINGS
11/22/00	678	PROVIDER TRACK NOTICE OF FILING SUPPLEMENTAL AUTHORITY from the American Medical Association by Cigna Corporation, Cigna Health, Connecticut General re: motion to compel arbitration (nt) [Entry date 11/28/00]
11/21/00	672	ALL TRACKS NOTICE TO THE PARTIES Re: Delayed Ruling on Motions to Compel Arbitration (Signed by Judge Federico A. Moreno on 11/20/00) CCAP [EOD Date: 11/28/00] (nt) [Entry date 11/28/00]
11/21/00	670	PROVIDER TRACK NOTICE of filing amended certificate of service for reply in support of motion to compel arbitration by Wellpoint Health (nt) [Entry date 11/28/00]
11/17/00	591	PROVIDER TRACK DECLARATION of Paula E. Ambrosini by Wellpoint Health Re: [457-1] motion to compel arbitration (nt) [Entry date 11/20/00]
11/17/00	590	PROVIDER TRACK REPLY by Wellpoint Health to response to [457-1] motion to compel arbitration (nt) [Entry date 11/20/00]
11/16/00	584	APPENDIX to: supplemental memorandum in support of [313-1] motion to compel arbitration, [317-1] motion to dismiss the complaint by Prudential Insurance (nt) [Entry date 11/20/00

DATE	NO.	PROCEEDINGS
11/16/00	583	PROVIDER TRACK SUPPLEMENT by United Healtcare, United Health Group to: [320-1] support memorandum to motion to dismiss (nt) [Entry date 11/20/00]
11/15/00	546	PROVIDER TRACK REPLY by Coventry of Georgia to response to motion to compel arbitration and stay proceedings (nt) [Entry date 11/16/00] [Edit date 04/11/01]
11/9/00	501	PROVIDER TRACK RESPONSE by Provider Plaintiffs to [483-1] motion to stay discovery pending the resolution of its petition to compel arbitration, [485-1] motion for an expedited briefing schedule and expedited consideration of motion to stay discovery (nt) [Entry date 11/13/00]
11/9/00	500	PROVIDER TRACK ORDER denying [483-1] motion to stay discovery pending the resolution of its petition to compel arbitration denying [485-1] motion for an expedited briefing schedule and expedited consideration of motion to stay discovery. (See Order for further details.) (by Judge Federico A. Moreno on 11/8/00) CCAP [EOD Date: 11/13/00] (nt) [Entry date 11/13/00]
11/8/00	497	PROVIDER TRACK RESPONSE by Provider Plaintiffs to [457-1] motion to compel arbitration (nt) [Entry date 11/09/00]
11/6/00	512	REPLY by Principal Health to brief in opposition to motion to compel arbitration and stay proceedings (timely filed per chamber's instructions) (nt) [Entry date 11/16/00]

DATE	NO.	PROCEEDINGS
11/6/00	492	SUPPLEMENTAL BRIEF by Pacificare, Inc., Pacificare Health in Response to Issues Presented to the Court at the 10/26/00 Hearing (nt) [Entry date 11/07/00]
11/1/00	484	MEMORANDUM of Points and Authorities by Wellpoint Health in support of [483-1] motion to stay discovery pending the resolution of its petition to compel arbitration (nt) [Entry date 11/02/00]
11/1/00	483	MOTION by Wellpoint Health to stay discovery pending the resolution of its petition to compel arbitration (nt) [Entry date 11/02/00]
10/30/00	478	PROVIDER TRACK ORDER OMNIBUS ORDER #2 Order Setting Revised Class Certification Briefing Schedule Order Denying Motion to Stay Action and Order Granting Motion for Case Management Conference granting [461-1] motion to extend time to file responsive pleadings to motion for class certification Response to motion reset to 11/17/00 for [443-1] motion to certify class action denying [402-1] motion to stay of action, denying [402-2] motion for discovery pending determination of motion to compel arbitration denying [411-1] motion to stay of discovery, denying [411-2] motion for protective order pending resolution of motion to compel arbitration granting [346-1] motion for case management conference, mooting [346-2] motion to stay, mooting [346-3] motion for reconsideration of [292-1] order in the

DATE	NO.	PROCEEDINGS
		PROVIDER TRACK cases, [288-1] order in the SUBSCRIBER TRACK cases granting [379-1] motion to join United's motion for case management conference. (See Order for further details.) (Signed by Judge Federico A. Moreno on 10/27/00) CCAP [EOD Date: 10/31/00] (nt) [Entry date 10/31/00]
10/26/00	467	PROVIDER TRACK DECLARATION of Suzanne K. Fogel by Wellpoint Health Re: [457-1] motion to compel arbitration (nt) [Entry date 10/27/00]
10/25/00	459	PROVIDER TRACK DECLARATION of Suzanne K. Fogel by Wellpoint Health Re: [457-1] motion to compel arbitration (nt) [Entry date 10/26/00]
10/25/00	459	NOTICE of filing original declaration of Suzanne K. Fogel by Wellpoint Health (nt) [Entry date 10/26/00]
10/25/00	458	MEMORANDUM of Points and Authorities by Wellpoint Health in support of [457-1] motion to compel arbitration (nt) [Entry date 10/26/00]
10/25/00	457	PROVIDER TRACK MOTION by Wellpoint Health to compel arbitration (nt) [Entry date 10/26/00]
10/16/00	424	PROVIDER TRACK NOTICE of filing corrected reply memorandum in support of motion to compel arbitration and to dismiss the complaint by Prudential Insurance (nt) [Entry date 10/17/00]

DATE	NO.	PROCEEDINGS
10/13/00	421	PROVIDER TRACK REPLY by United Healtcare, United Health Group to response to [319-1] motion to dismiss amended complaint (nt) [Entry date 10/16/00]
10/13/00	420	PROVIDER TRACK REPLY by Foundation Health to response to [314-1] motion to dismiss complaint, [314-2] motion to compel arbitration (nt) [Entry date 10/16/00]
10/13/00	415	PROVIDER TRACK REPLY MEMORANDUM by Cigna Corporation, Cigna Health to response to [323-1] motion to compel arbitration, [310-1] motion to dismiss provider track amended complaint (nt) [Entry date 10/16/00]
10/13/00	414	PROVIDER TRACK REPLY MEMORANDUM by Prudential Insurance in support of [317-1] motion to dismiss the complaint, [313-1] motion to compel arbitration (nt) [Entry date 10/16/00]
10/13/00	411	PROVIDER TRACK EMERGENCY MOTION by Prudential Insurance to stay of discovery, and for protective order pending resolution of motion to compel arbitration (nt) [Entry date 10/16/00]
10/11/00	402	PROVIDER TRACK MOTION by Cigna Corporation, Cigna Health, Connecticut General to stay of action, and for discovery pending Court's determination of motion to compel arbitration (nt) [Entry date 10/12/00]

DATE	NO.	PROCEEDINGS
10/11/00	398	PROVIDER TRACK Notice of compliance with Rule 26.1(I) in Reference to Motion for a Stay of Action and Discovery Pending Court's Determination of Motion to Compel Arbitration by Cigna Corporation, Cigna Health, Connecticut General (nt) [Entry date 10/12/00]
10/6/00	388	PROVIDER TRACK CONSOLIDATED RESPONSE AND MEMORANDUM OF LAW TO DEFENDANTS' MOTION TO DISMISS ANS TO COMPEL ARBITRATION by Provider Plaintiffs to [323-1] motion to compel arbitration, [319-1] motion to dismiss amended complaint, [317-1] motion to dismiss the complaint, [314-1] motion to dismiss complaint, [314-2] motion to compel arbitration, [313-1] motion to compel arbitration, [312-1] motion to dismiss all claims pursuant to Fed. R. Civ. Proc. 9(B) and 12(B)(6), [310-1] motion to dismiss provider track amended complaint, [307-1] motion to dismiss amended complaint action, [264-1] motion to dismiss amended complaint, motion to dismiss for improper venue, [257-1] motion to compel arbitration, [257-2] motion to dismiss all claims, [239-1] motion to dismiss first amended complaint pursuant to Federal Rule of Civil Procedure 12(b), [154-1] motion to dismiss the first amended complaint (nt) [Entry date 10/11/00]

DATE	NO.	PROCEEDINGS
10/5/00	384	PROVIDER TRACK OMNIBUS ORDER #1 denying [254-1] motion to extend time to respond to Shane's amended complaint denying [255-1] joint motion to extend time to respond to provider plaintiffs' complaint denying [256-1] motion to extend time to respond to Shane's amended complaint granting [259-1] motion for oral argument on [257-1] motion to compel arbitration, [257-2] motion to dismiss all claims setting motion hearing on [257-1] motion to compel arbitration by Pacificare, Inc., Pacificare for 9:00 10/26/00, setting motion hearing on [257-2] motion to dismiss all claims by Pacificare, Inc., Pacificare for 9:00 10/26/00 granting [262-1] motion for Oral Argument on [260-1] motion for suggestion of remand, [260-2] motion to dismiss for improper venue setting motion hearing on [260-1] motion for suggestion of remand by Pacificare, Pacificare Health for 9:00 10/26/00, setting motion hearing on [260-2] motion to dismiss for improper venue by Pacificare, Inc., Pacificare Health for 9:00 10/26/00 denying [263-1] motion to extend time to respond to complaint denying [280-1] motion to extend time to respond to amended complaint granting [334-1] motion to continue the deadline for Wellpoint to bring a motion to dismiss reset answer due for 10/9/00 for Wellpoint Health (See Order for further details.) (Signed by Judge Federico A. Moreno on 10/4/00) CCAP

DATE	NO.	PROCEEDINGS
		[EOD Date: 10/6/00] (nt) [Entry date 10/06/00]
9/28/00	337	PROVIDER TRACK NOTICE of Correction of Motion to Dismiss or in the alternative, to Compel Arbitration by Foundation Health (nt)
9/26/00	323	PROVIDER TRACK MOTION with memorandum in support by Cigna Corporation, Cigna Health, Connecticut General to compel arbitration (nt) [Entry date 09/27/00]
9/22/00	321	PROVIDER TRACK APPENDIX to: [320-1] support memorandum by United Healtcare, United Health Group (nt) [Entry date 09/25/00]
9/22/00	320	PROVIDER TRACK MEMORANDUM by United Healtcare, United Health Group in support of [319-1] motion to dismiss amended complaint (nt) [Entry date 09/25/00]
9/22/00	319	PROVIDER TRACK MOTION by United Healtcare, United Health Group to dismiss amended complaint (nt) [Entry date 09/25/00]
9/22/00	315	PROVIDER TRACK MEMORANDUM by Foundation Health in support of [314-1] motion to dismiss complaint, [314-2] motion to compel arbitration (nt) [Entry date 09/25/00]
9/22/00	314	PROVIDER TRACK MOTION by Foundation Health to dismiss complaint, or in the alternative to compel arbitration (nt) [Entry date 09/25/00]

DATE	NO.	PROCEEDINGS
9/22/00	313	PROVIDER TRACK MOTION by Prudential Insurance to compel arbitration (nt) [Entry date 09/25/00]
9/8/00	259	PROVIDER TRACK MOTION by Pacificare Health, Pacificare, Inc. for oral argument on [257-1] motion to compel arbitration, [257-2] motion to dismiss all claims (nt) [Entry date 09/11/00]
9/8/00	258	PROVIDER TRACK DECLARATION of Kevin Roddy & Cathy N. Batteer by Pacificare Health, Pacificare, Inc. Re: [257-1] motion to compel arbitration, [257-2] motion to dismiss all claims (nt) [Entry date 09/11/00]
9/8/00	258	NOTICE of filing declarations by Pacificare Health, Pacificare, Inc. (nt) [Entry date 09/11/00]
9/8/00	257	PROVIDER TRACK MOTION by Pacificare Health, Pacificare, Inc. to compel arbitration, and to dismiss all claims (nt) [Entry date 09/11/00]
8/14/00	167	AMENDED COMPLAINT , (Answer due 8/24/00 for Humana, Inc., for Connecticut General, for Cigna Health, for Cigna Corporation, for Aetna-US, for Aetna, Inc., for Humana Health Plan, for United Health Group, for United Healtcare, for Prudential Insurance, for Pacificare Health, for Foundation Health) adding Cigna Healthcare, Pacificare, Inc., Wellpoint Health (nt) [Entry date 08/15/00]

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 01-10247-C and No. 01-12596-CC

PACIFICARE HEALTH SYSTEMS, INC., *et al.*,
Petitioners,

v.

JEFFREY BOOK, D.C., *et al.*,
Respondents.

DOCKET ENTRIES

DATE	PROCEEDINGS
01/23/01	Civil Appeal Statement Form: Appellant-PacifiCare health Systems, Inc., PacifiCare Health Systems
01/24/01	Civil Appeal Statement Form: Appellant-United Health Care, United Health Care
03/30/01	Appellant's Brief Filed: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace): Appellant-PacifiCare Operations, Inc., (Atty: Christopher R.J. Pace). PacifiCare Operations, Inc.
04/02/01	Record Excerpts: Joint rex for all Appellants N/A
04/02/01	Appellant's Brief Filed: Appellant-Prudential Insurance Company of America, signed by Ronald Ravikoff. Prudential Insurance
04/02/01	Appellant's Brief Filed: Appellant-United Health Care, Appellant-United Health Group, signed Jeffrey Klein, United Health Group

DATE	PROCEEDINGS
04/03/01	Appellant's Brief Filed: Appellant-Foundation Health Systems, Inc., signed by Mark Filip. N/A
04/03/01	Appellant's Brief Filed: Appellant-Wellpoint Health Networks, Inc., signed by Stan Blumenfeld. Wellpoint Health Networks
05/15/01	Appellants' Motion to Stay Proceedings in the District Court. N/A
05/15/01	Motion to Expedite Review of Appellants' Motion for Stay. N/A
05/21/01	Response to Motion: Appellee with appendix in support. N/A
05/29/01	Reply Response to Motion for Stay Proceedings. N/A
06/04/01	Appellee Brief Filed: Pt'd (COS w/o date) M6/7 Appellees-Freyre, Patricia; Johnson, Sandra; Johnson, Sandra; Katz, Arnold; Price Plaintiffs; Price, Regina Joi; Sessa, Anthony; Yingling, Dawn; signed by Dennis Pantazis. N/A
06/18/01	Reply Brief Filed: Appellant-Foundation Health Systems, Inc., (Atty: Edward M. Crane): Appellant-Prudential Insurance Company of America, (Atty: John D. Aldock): Appellant-Wellpoint Health Networks, Inc., (Atty: Franklin G. Burt). Wellpoint Health Networks
06/18/01	Reply Brief Filed: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace): Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace). PacifiCare Health Systems

DATE	PROCEEDINGS
06/20/01	Reply Brief Filed: Appellant-United Health Care, (Atty: Kenneth P Gavsie): Appellant-United Health Group, (Atty: Kenneth P Gavsie): Appellant-United Health Group, (Atty: Kenneth P Gavsie). United Health Group
06/22/01	1st Supplemental Record On Appeal. N/A
06/25/01	Appellants' motion to stay further proceedings in the district court pending disposition of this appeal is GRANTED. Appellants' motion for expedited consideration of their motion to stay is DENIED AS MOOT. N/A
06/25/01	MOT2 (Motion- Court Action) issued. N/A
07/02/01	Unopposed Motion to Consolidate: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace): Appellant-PacifiCare Operations, Inc., (Atty: Christopher R.J. Pace). PacifiCare Operations, Inc.
07/03/01	Exhibits. N/A
07/03/01	Record on Appeal (vol. 6 is sealed). N/A
07/10/01	Unopposed Motion to Consolidate w/01-12596-CC is GRANTED by AW. Issued 7/11/01.: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace). N/A
07/11/01	MOT2 (Motion-Court Action) issued. N/A
07/13/01	Appellees' Motion for Limited Relief from Stay/Expedite Appeal. N/A
07/20/01	2nd Supplemental Exhibits. N/A
07/20/01	2nd Supplemental Record on Appeal. N/A

DATE	PROCEEDINGS
07/24/01	Response to Motion to Lift Stay: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace). PacifiCare Health Systems
07/25/01	Response to Motion to Lift Stay/Expedite: Appellant-United Health Care, (Atty: Kenneth P Gavsie): Appellant-United Health Group, (Atty: Kenneth P Gavsie). United Health Group
07/26/01	Supplemental Authority for Appellant: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace); Appellant-PacifiCare Operations, Inc., (Atty: Christopher R.J. Pace). PacifiCare Operations, Inc.
07/30/01	Notice of filing: Notice and Stipulation of Resolution of Motion to Partially Lift Stay, which is construed as Motion to Withdraw Motion to Lift Stay. N/A
08/07/01	. . . motion to expedite consideration of these appeals is GRANTED . . . Appellants' "request for Style Realignment . . . ," . . . is DENIED . . . Appellees' request to change the style . . . is DENIED . . . (see file for complete text). N/A
08/07/01	MOT2 (Motion-Court Action) issued. N/A
08/07/01	MOT2 (Motion – Court Action) issued. N/A
01/16/02	Walter E. Dellinger argued for Appellant; James B. Tilghman, Jr argued for Appellee. N/A
2/11/02	Motion for Leave to File Supplemental One-Page Brief: Appellant-Foundation Health Systems, Inc., (Atty: Walter E. Dellinger). Foundation Health Systems

DATE	PROCEEDINGS
2/13/02	Response to Motion for Leave to File Supplemental Brief, also construed as, Motion for Leave to File Response Supplemental Brief: Appellee-Price, Regina Joi. Price, Regina Joi
2/19/02	Supplemental Authority for Appellant: Appellant-Foundation Health Systems, Inc., (Atty: Walter E. Dellinger). Foundation Health Systems
02/27/02	Appellants' motion and Appellees' response, also construed as a motion, for leave to file supplemental briefs are DENIED. RB/j/. N/A
02/27/02	MOT2 (Motion—Court Action) issued. N/A
03/14/02	OPIN1A (Opinion—Issuance with Costs) issued.. N/A
03/14/02	Opinion Issued 01-10248x, 01-10249x, 01-10250x, 01-10437x, consol. and also filed w/01-12596. N/A
03/14/02	Judgment Entered. N/A
03/26/02	Appellees' Motion to Lift Stay; Appellee-Price Plaintiffs, (Atty: Charles P. Ford) (MOOT—see Court's opinion dated 3/14/02). Price Plaintiffs
04/04/02	Petition for Rehearing En Banc: Appellant-Foundation Health Systems, Inc., (Atty: Walter E. Dellinger). Foundation Health Systems
04/08/02	Appellants' Response to Motion to Lift Stay: Appellant-Foundation Health Systems, Inc., (Atty: Walter E. Dellinger). Foundation Health Systems

DATE	PROCEEDINGS
06/21/02	The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc, the Petition(s) for Rehearing En Banc are DENIED.: Appellant-Foundation Health Systems. N/A
06/21/02	REHG1 (Rehearing—Transmittal) issued. N/A
06/26/02	Motion to Stay Mandate: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace): Appellant-PacifiCare Operations, Inc., (Atty: Christopher R.J. Pace): Appellant-United Health Care, (Atty: Kenneth P. Gavsie): Appellant-United Health Group,. United Health Group
07/03/02	Appellees' Response to Motion to Stay Mandate: Appellee-Price Plaintiffs, (Atty: Harley S. Tropin). Price Plaintiffs
07/10/02	The motion of Apppellants,...for stay of the issuance of the mandate pending petition for writ of certiorari is DENIED. RB/j/. N/A
07/10/02	MOT2 (Motion – Court Action) issued. N/A
07/22/02	CASE CLOSED-Mandate Issued. N/A
07/22/02	Mandate Issued. N/A
07/22/02	MDT1 (Mandate—Issuance) issued. cc: Dobbins, M. David. N/A
08/28/02	Notice of Filing Certiorari-SC# 02-215: Appellant-PacifiCare Health Systems, Inc., (Atty: Christopher R.J. Pace). PacifiCare Health Systems

DATE	PROCEEDINGS
10/18/02	Certiorari Granted-sc# 02-215. N/A
11/21/02	REC3 (Record—Return) issued. To Clarence Maddox. N/A

PACIFICARE OF FLORIDA, INC.

PHO SERVICES AGREEMENT

This PHO SERVICES AGREEMENT is made and entered into this 1st day of April, 1995, by and between PacifiCare of Florida, Inc. ("PacifiCare of Florida") a Florida corporation, and *SOUTHWEST FLORIDA PHO* ("SWFPHO") with reference to the following facts:

A. PacifiCare is a licensed health maintenance organization ("HMO") in the state of Florida which operates various prepaid health service plans, including Commercial, Medicare and Medicaid plans, which arrange for certain Medical and Hospital Services to be provided to persons who are enrolled as Members in the PacifiCare Health Plan in a manner consistent with the laws of the United States and the State of Florida.

B. SWFPHO is a Physician Hospital Organization which contracts for its providers to provide primary and specialty physician services. It also provides other administrative services which support the delivery of care by its providers.

C. Physician is a duly licensed doctor of medicine or osteopathy under the laws of the State of Florida. Primary Care Physician, (PCP) is experienced in providing Primary Care Services and coordinating Referral Services, as defined below. A specialty physician experienced in providing medical care and coordinating specialty care, as defined below.

D. For purposes of this agreement the term PHYSICIAN shall mean any credentialed physician or other healthcare professional delivering care within the contractual relationship between the SWFPHO and PacifiCare.

E. PacifiCare desires for PHYSICIAN to provide Primary Care/Specialty Services and arrange to serve

members of PacifiCare of Florida, subject to the terms and conditions set forth below.

NOW, THEREFORE, in consideration of the promises and mutual covenants contained herein, the parties agree as follows:

F. SWFPHO has authority to enter into an Agreement on behalf of its Affiliated Providers, which may include Primary Care Physicians, Physician Specialists and Ancillary Providers and to legally bind the Affiliated Providers to provide Medical Services to Subscribers in the PHO's service area.

1. DEFINITIONS

1.01 AGREEMENT—is this agreement for Primary Care and Specialty Services, dated as herein above stated, including all appropriate attachments and any amendments hereto.

1.02 AHCA—is the Agency for Health Care Administration, an administrative agency of the State of Florida, responsible for administering the state Medicaid program.

1.03 CAPITATION PAYMENTS—are payments made to PCP by PacifiCare on a prepaid basis as set forth in Attachment B for the Covered Services to be provided or arranged under this Agreement.

1.04 COMMERCIAL MEMBER—is an individual who is enrolled in the PacifiCare Commercial Health Plan.

1.05 COPAYMENTS—are charges pursuant to the PacifiCare Health Plan which may be charged to a Member by a Physician at the time of provision of Medical Services, which are in addition to the Capitation and fee-for-service payments made to PHYSICIAN by PacifiCare.

1.06 COVERED SERVICES—are all authorized Medical Services, Hospital Services and other health care services, including Emergency Services and Urgently Needed Services, which are covered benefits under the applicable PacifiCare Health Plan.

1.07 COVERING PHYSICIAN—is a family practitioner, general practitioner, internist or pediatrician licensed by the State of Florida, who has entered into an agreement, either oral or written, with PCP to provide health services to PCP's patients when PCP is not available. A Covering Physician may or may not be under contract with PacifiCare. If PCP fails to identify a Covering Physician as set forth Section 3.05 of this Agreement, PacifiCare may do so on PCP's behalf.

1.08 ELIGIBILITY LIST—is the list of Members to whom PCP is responsible for providing Primary Care Services and arranging Referral Services, which list is provided by PacifiCare to PCP on a monthly basis.

1.09 EMERGENCY SERVICES—are Covered Services which are immediately required as the result of an unexpected and unforeseen disease, illness or injury that could reasonably be expected to result in disability or death if not treated immediately.

1.10 MEDICALLY NECESSARY SERVICES—are Covered Services which are necessary and appropriate for the Member's condition based upon accepted medical and surgical practices in the community at the time care or treatment is provided as determined by PacifiCare's Medical Director.

1.11 MEDICAID—is the federally and state funded program of medical assistance for impoverished individuals who are aged, blind, or disabled or members of families with dependent children established by Title XIX of the Social

Security Act, as amended, which is administered in Florida by the AHCA.

1.12 MEDICAID MEMBER—is a person who is eligible to receive Medicaid benefits and who is enrolled as a Member in the PacifiCare Medicaid Plan. Unless otherwise specified, all references in the Agreement to member shall include Medicaid Member.

1.13 MEMBER—is any person who meets the eligibility requirements for membership in the PacifiCare Health Plan, who is enrolled in such plan, and for whom the applicable premiums have been received by PacifiCare. Members shall include all eligible dependents of the individual named by PacifiCare for coverage under the PacifiCare Health Plan.

1.14 NCQA—is the National Committee for Quality Assurance, an entity responsible for accreditation of Health Maintenance Organizations.

1.15 PACIFICARE COMMERCIAL HEALTH PLAN—is the prepaid health services plan or plans sold by PacifiCare to individuals (excluding individuals eligible for the PacifiCare Medicaid Plan) and employer groups, associations with employer group participation and unions which purchase benefits for the benefit of their employees and dependents, as described in the PacifiCare Medical and Hospital Group Subscriber Agreement and the PacifiCare Medical and Hospital Individual Conversion Subscriber Agreement and attachments, addenda, supplements and periodic amendments thereto. Unless otherwise specified, references to the PacifiCare Health Plan shall include the PacifiCare Commercial Health Plan.

1.16 PACIFICARE HEALTH PLAN—is any one of various managed care products sponsored or administered by PacifiCare or its subsidiaries or affiliates including, without limitation, the PacifiCare Commercial Health Plan and the

PacifiCare Medicaid Risk Plan, and any additional managed care products sponsored or developed by PacifiCare or its subsidiaries or affiliates. PacifiCare will notify SWFPHO of any changes or additions to the managed care products.

1.17 PACIFICARE MEDICAID PLAN—is the prepaid health services plan operated by PacifiCare covering the provision of Medical and Hospital Services to persons eligible to receive Medicaid benefits, as described in the PacifiCare Medicaid Medical and Hospital Subscriber Agreement and attachments, addenda, supplements and periodic amendments thereto. Unless otherwise specified, references to the PacifiCare Health Plan shall include the PacifiCare Medicaid Plan.

1.18 PACIFICARE SERVICE AREA—is the geographic area in which PacifiCare is licensed (i) by the Florida Department of Insurance to offer the PacifiCare Commercial Health Plan, and (ii) by the AHCA to offer the PacifiCare Medicaid Plan.

1.19 PARTICIPATING HOSPITALS—are licensed general acute care hospitals, skilled nursing facilities, extended care facilities, home health agencies, alcoholism and substance abuse centers or any other health care facility licensed by the State of Florida which has entered into a written agreement with PacifiCare to provide Covered Services to Members pursuant to the PacifiCare Health Plan.

1.20 PHYSICIAN—Physician is a duly licensed doctor of medicine or osteopathy under the laws of the State of Florida. Primary Care Physician, (PCP) is experienced in providing Primary Care Services and coordinating Referral Services, as defined below. A specialty physician experienced in providing medical care and coordinating specialty care, as defined below. Physician shall mean PCP and/or Specialist as appropriate.

1.21 PRIMARY CARE PHYSICIAN—is a family practitioner, general practitioner, internist or pediatrician licensed by the State of Florida who has entered into a written agreement with PacifiCare to provide, arrange and coordinate all Covered Services to Members who have selected or been assigned to such Primary Care Physician pursuant to the PacifiCare Health Plan.

1.22 PRIMARY CARE SERVICES—are those Medically Necessary Services generally provided by fully trained primary care medical doctors, in the state of Florida, to all of their patients including those services set forth in Attachment B.

1.23 QUALITY IMPROVEMENT COMMITTEE—is the committee established by PacifiCare which shall establish, maintain and perform quality assurance reviews of Covered Services provided to Members as reasonably required by PacifiCare, the NCQA, the Florida Department of Insurance, the AHCA, the United States Department of Health and Rehabilitative Services, the Agency for Health Care Administration and any other governmental agencies with jurisdiction over PacifiCare or this Agreement.

1.24 REFERRAL SERVICES—are recommended directions of Members from Primary Care Physicians to Specialist Physicians, providers of ancillary services such as laboratory, diagnostic, health education, medical social service, home health care, behavioral health, for the purpose of obtaining Covered Services.

1.25 SCHEDULE OF BENEFITS—means the schedule of Covered Services corresponding to the health services plan under which a particular Member has enrolled. The Schedule of Benefits also lists certain items or services which are excluded or limited. Any service obtained by Members which is excluded or which has exceeded the

limitation for that service is not a Covered Service and will be the responsibility of the Member.

1.26 SPECIALIST PHYSICIAN—is a physician, surgeon or osteopath licensed to practice medicine by the State of Florida (other than a Primary Care Physician) who has entered into a written agreement with PacifiCare to provide Covered Services to Members on a Referral basis.

1.27 URGENTLY NEEDED SERVICES—are Covered Services which are required without delay in order to prevent serious deterioration of a Member's health as the result of an unforeseen illness or injury while the Member is temporarily absent from the PacifiCare Service Area.

1.28 UTILIZATION REVIEW COMMITTEE—is a PacifiCare committee established and maintained to develop a utilization control program outlining procedures for the efficient use of resources, consistent with state and federal law, for the provision of Covered Services. The Utilization Review Committee shall review elective referrals and hospital admissions on a concurrent and prospective basis and Emergency Services, Urgently Needed Services and hospital admissions on a retrospective basis.

1.29 HCFA—is the Health Care Financing Administration, an administrative agency of the United States Government.

1.30 CATASTROPHIC CASE - is any single medical condition, including complications arising from such medical condition, where the total cost of Health Care Services to treat such condition is expected to exceed Seventy five thousand dollars ($75,000.00) per condition.

1.31 MONTHLY HCFA PAYMENT—is the revenue received by PacifiCare each month from HCFA, as determined by HCFA, for the Health Care Services each subscriber is to be provided minus any Benefit Withhold.

1.32 RETIREE SUBSCRIBER—is a subscriber enrolled in the Secure Horizons Retiree Health Plan, who meets all the eligibility requirements for membership in such plan and for whom all applicable premiums have been paid and received by PacifiCare.

2. RELATIONSHIP OF PARTIES

2.01 INDEPENDENT CONTRACTOR—The relationship between PacifiCare and PHYSICIAN is an independent contractor relationship. Neither PHYSICIAN nor any employees or agents of PHYSICIAN are employees, or agents of PacifiCare and neither PacifiCare nor any employee or agent of PacifiCare is an employee, or agent of PHYSICIAN. As such, all medical decisions regarding Primary Care Services are rendered solely by PHYSICIAN and not by PacifiCare. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control, or employment between the parties.

2.01.01 RELATIONSHIP WITH PACIFICARE OR PHYSICIAN AND AHCA OR THE STATE OF FLORIDA—The relationships between PacifiCare and PHYSICIAN, as a subcontractor of PacifiCare, and the AHCA and the State of Florida are independent contractor relationships. Neither PacifiCare nor PHYSICIAN nor any agents, officers or employees of PacifiCare or PHYSICIAN are agents, officers or employees of the AHCA or the State of Florida. None of the provisions of this Agreement shall be construed to create a relationship of partnership, joint venture or employment between PacifiCare or PHYSICIAN, as a subcontractor of PacifiCare, and the AHCA or the State of Florida.

2.02 RESPONSIBILITIES FOR ACTS AND OMISSIONS—~~IPA~~ [Handwritten: *PHO* [*SEL 3/15/95*] [*DS*]] and PacifiCare acknowledge and agree that each party shall

be responsible for its own acts and omissions under this Agreement and neither ~~IPA~~ [Handwritten: [*PHO* [*SEL 3/16/95*] [*DS*]] nor PacifiCare shall be responsible for the acts or omissions of the other.

2.03 PHYSICIAN-PATIENT RELATIONSHIP—PacifiCare and PHYSICIAN acknowledge and agree that the PHYSICIAN shall maintain the PHYSICIAN-patient relationship with each Member. The PHYSICIAN shall have the sole responsibility for the medical care and treatment of Members under such PHYSICIAN's care. Nothing contained in this Agreement is intended to interfere with such PHYSICIAN-patient relationship.

3. DUTIES OF PCP

3.01 PHYSICIAN RESPONSIBILITIES—PHYSICIAN shall provide Primary Care Services, as defined in Attachment A, within the Service Area to Members on PHYSICIAN's Eligibility List. Such Primary Care Services shall be available twenty-four (24) hours per day. PHYSICIAN shall be financially responsible for all Primary Care Services provided to eligible Members for whom PHYSICIAN receives a monthly Capitation Payment from PacifiCare based upon the PacifiCare Eligibility List. PHYSICIAN shall be responsible for determining whether Members are eligible for Primary Care Services on the basis of the Eligibility List supplied to PHYSICIAN by PacifiCare.

3.02. STANDARDS—PCP shall provide Primary Care Services and arrange Referral Services in accordance with generally accepted standards of medical practice and the standards established by the PacifiCare Utilization Review Committee and Quality Improvement Committee. PCP agrees to maintain and demonstrate to PacifiCare upon request, throughout the term of this Agreement, compliance with the following:

3.02.01 Licensure as appropriate under the laws of the State of Florida.

3.02.02. Written assurances that all nurses and other ancillary and para-medical personnel employed by PCP are properly credentialed to practice in the State of Florida.

3.02.03 Medical staff membership and unrestricted applicable clinical privileges for at least one Participating Hospital in the PacifiCare Service Area, unless specifically exempted in writing by PacifiCare.

3.02.04 Maintenance of current Florida Drug Enforcement Agency ("DEA") Registration.

3.02.05 Compliance with the credentialing standards of PacifiCare, by providing, upon request, information concerning PCP's education, training, reference, malpractice liability insurance, and, if applicable, hospital staff status, hospital clinical privileges, and hospital staff reappointment dates. PCP shall notify PacifiCare in writing immediately of any of the following actions taken by or against a PCP: (i) the surrendering, revocation or suspension of a license or a current DEA registration; (ii) any action to restrict, suspend or revoke the PCP's medical staff privileges for a period of time greater than thirty (30) days; (iii) any lapse or material change in PCP's professional liability insurance required by this Agreement; (iv) any indictment, arrest, or conviction for a felony or for any criminal charge related to the practice of PCP's profession; (vii) any other situation which would materially affect PCP's ability to carry out his or her duties and obligations under this Agreement, or which would materially change the representations made in PCP's credentialing application.

3.03 EMPLOYED AND SUBCONTRACTED PHYSICIANS—PCP hereby guarantees and certifies that each employed or subcontracted physician or other licensed non-technician medical provider shall abide by all the terms

and conditions of this Agreement. Further, PCP must notify within 30 days of anticipating the start date of any new employed or subcontracted physician in order to allow PacifiCare adequate time to initiate and complete the credentialing process prior to the physician providing Medical Services to a PacifiCare Member.

3.04 COMPLIANCE WITH CIVIL RIGHTS LAWS—PCP shall comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975 as required by applicable laws or regulations.

3.05 HOSPITAL ADMISSIONS—Whenever PCP determines that a Member on PCP's eligibility list requires Hospital Services that are not Emergency Services, PCP shall arrange for such hospital admission and notify PacifiCare of such admission in advance. Admissions for Emergency Services shall be made to Participating Hospitals, if possible. PacifiCare may require review of certain non-emergency hospital admissions prior to authorization.

3.06 PROVISION OF SERVICES—PCP shall make necessary and appropriate arrangements with Covering Physician(s) to ensure the availability of Primary Care Services to its Members twenty-four (24 hours per day, seven (7) days per week, including arrangements to ensure coverage of its Members after hours or when PCP is otherwise absent, consistent with PacifiCare's access to care guidelines. PCP shall ensure that such covering physician w(s) will adhere to the PacifiCare policies and procedures and the terms of this Agreement as to the services provided to Members and that such covering physician(s) will seek authorization from PacifiCare prior to all referrals and hospitalizations of Members, except for Emergency Services or Urgently Needed Services.

3.06.01 For Primary Care Services or any other services rendered by Covering Physician(s) on behalf of PCP, PCP shall be solely liable to the Covering Physician(s) for the amount and manner in which said Covering Physician(s) will be reimbursed or otherwise compensated; provided, further, that PCP shall ensure that the Covering Physician(s) will not, under any circumstances, bill Members or PacifiCare for Covered Services other than Members for applicable co-payments. Except as aforesaid, PCP hereby agrees to indemnify and hold harmless ~~PacifiCare,~~ [Handwritten: [*SEL 3/16/95*] [*DS*]] the AHCA, and its Members from and against all charges for Covered Services rendered by Covering Physician(s), [Handwriten: *except copays, deductibles, and charges for non-covered services.* [*SEL 3/16/95*] [*DS*]]

3.07 REFERRAL SERVICES—PCP shall arrange for Referral Services to the appropriate participating specialist physicians and Participating Hospitals to Members on PCP's Eligibility List, as medically necessary, and shall follow the clinical progress and provide case management services to those Members until they return to PCP's care.

3.08 REFERRALS TO SPECIALISTS—Physician shall refer Member in need of Referral Services only to Specialist Physicians with whom PacifiCare has a contractual relationship. PacifiCare may require review of certain referrals prior to authorizations. In the event Emergency Services are required, Physician shall comply with Section 3.05 hereof.

3.09 COLLECTION OF CHARGES FROM THIRD PARTIES—PHYSICIAN accepts payment from PacifiCare for Medical Services as provided herein as full payment for such services; however, in the event of third-party liability, Worker's Compensation claims, or other primary insurance coverage, PHYSICIAN shall be entitled to all reimbursement received from such primary sources of payment for all Medical Services. In the event PHYSICIAN receives

payment from such primary sources, PHYSICIAN shall reimburse PacifiCare any amounts paid by PacifiCare to Physician for such services within thirty (30) days after receiving payment from such primary sources. The amount reimbursed by PHYSICIAN to PacifiCare shall not exceed the amount initially paid by PacifiCare. Physician may collect and bill charges from third parties for COB reinsurance and stop loss.

3.10 INSURANCE

3.11 COLLECTION OF CHARGES FROM MEMBERS—PCP shall collect applicable Copayments and deductibles from Members upon rendering Primary Care Services to Members pursuant to the PacifiCare of Florida. With the exception of Copayments, deductibles and charges for non-covered services, PCP shall not, in any event, including, without limitation, non-payment by PacifiCare, insolvency of PacifiCare, or breach of this Agreement, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against Members or persons other than PacifiCare for services provided pursuant to this Agreement.

PCP further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Members and that (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between PCP and the Member or persons acting on Member's behalf.

3.12 ADMINISTRATIVE GUIDELINES—PCP agrees to perform its duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by PacifiCare in its Provider Policies and Procedures Manual. The Provider Policies and Procedures Manual is subject to revision upon thirty (30) days written

notice to PCP by PacifiCare. [Handwritten: *The previous sentence notwithstanding, any provision that substantively alters the PCP's ability to comply with policies or procedures will not go into effect if the PCP provides written notice to PacifiCare or the PHO within 30 days of receiving such revision(s). Such notice by PCP shall include reason(s) why such revision(s) are not acceptable.* [*SEL 3/16/95*] [*DS*]] In the event of conflict between such manual and this Agreement, the terms of this Agreement shall prevail.

3.13 QUALITY IMPROVEMENT PROGRAM AND UTILIZATION MANAGEMENT PROGRAM—PCP shall participate in and comply with the PacifiCare Quality Assurance Program. PCP also agrees to participate with PacifiCare in an ongoing utilization review program, through the Utilization Review Committee, to promote efficient use of resources. PCP shall furnish pertinent sections of a Member's medical records as may be required to implement such programs. PCP shall utilize the criteria for medical care established or approved by PacifiCare's Quality Improvement Committee and Utilization Review Committee.

3.14 CAPACITY REPORTING—PCP will provide to PacifiCare, at the earliest possible time, notice of any significant changes in the capacity of PCP, including a ninety (90) day written notice in the event the PCP is unable or does not wish to serve additional Members. Such notice shall be applicable to all PacifiCare Health Plans.

3.15 DISCLOSURE OF INFORMATION—PacifiCare may use PCP's name, address and telephone number in PacifiCare materials including PacifiCare's provider directory. PCP shall obtain the prior written consent of PacifiCare prior to using PacifiCare's name in its advertising or for any other reason.

3.16 NONDISCRIMINATION—PCP represents and assures that PCP shall not discriminate between PacifiCare

Members and his/her other patients due to race, sex, age, religion, place of residence, health status, or source of payment.

3.17 PROTECTION OF MEMBER—PCP may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients of the PCP. PCP may not require the transfer, discharge, or removal of any Member because of the Member's need for, or utilization of, Medically Necessary Services. Procedures for removal, discharge, or transfer of Members shall be carried out in accordance with the procedures set forth in the Provider Policies and Procedures Manual.

3.18 TRANSFER OF MEMBERS—PacifiCare and PCP shall exercise reasonable efforts in following the procedures for transfer, discharge or removal of Members as set forth in the PacifiCare Policies and Procedures Manual and in discouraging Member transfers except at re-enrollment periods, or when a Member can show just cause for such transfer and PacifiCare agrees to such transfer. Nevertheless, PacifiCare may require transfer of Members assigned to PCP for any reason or PCP may request transfer of Members assigned to him/her by PacifiCare to other Participating Providers if the capacity of PCP is overburdened so that the provision of Medical Services as required by this Agreement is affected.

3.19 VACCINES FOR CHILDREN PROGRAM—PCP participating in the Medicaid plan agrees to participate in the State of Florida's Vaccines for Children Program, a federally-funded and state-operated immunization program, as described in Attachment D to this Agreement.

~~3.20 RECIPROCITY AGREEMENTS SWFPHO agrees to develop agreements among PacifiCare's Participating Medical Groups to assure reciprocity of health care among the Participating Medical Groups for PacifiCare~~

~~Subscribers. SWFPHO shall accept non-emergency or specialty Referrals from such other Participating Medical Groups and such other Participating Medical Groups shall be required to accept non-emergency or specialty Referrals from PHO. Payment for the foregoing Referrals shall be no greater than the Cost of Care Rates.~~ [Handwritten: *Delete* [*SEL 3/16/95*][*DS*]]

4. DUTIES OF SPECIALIST

During the term of this Agreement:

4.01 PHYSICIAN RESPONSIBILITIES—PHYSICIAN agrees to provide Specialty Services on a twenty-four (24) hour basis in the Service Area, Medical Services to Members referred to Physician by a PacifiCare contracted Primary Care Physician. In the event of a call, the Physician covering for a Specialist and rendering care in good faith, said services will be compensated at the rate agreed upon by the original consultant. The preference of PacifiCare is that the patient would be directed to their Primary Care Physician for direction in these circumstances. PHYSICIAN shall be responsible for determining whether Members are eligible for Medical Services.

4.02 STANDARDS—All Medical Services arranged for or provided by PHYSICIAN shall be provided by professional personnel and PHYSICIAN facilities according to generally accepted standards of medical practice and medical management. PHYSICIAN further agrees to provide or arrange for referrals as are necessary, appropriate, and in accordance with generally accepted standards of medical practice to maintain the quality of health care services provided or arranged by PHYSICIAN in accordance with PacifiCare's Quality Assurance Program provided at the time of contracting. PHYSICIAN agrees to maintain and demonstrate to PacifiCare upon request, throughout the term of this Agreement, compliance with the following:

4.02.01. Licensure under the laws of the State of Florida.

4.02.02 Written assurances that all nurses and other ancillary and para-medical personnel employed by PHYSICIAN are properly credentialed to practice in the State of Florida.

4.02.03 Medical staff membership and unrestricted applicable clinical privileges for at least one PacifiCare Participating Hospital in the Service Area, unless specifically exempted in writing by PacifiCare.

4.02.04 Maintenance of current Drug Enforcement Agency ("DEA") Registration.

4.02.05

4.03 REFERRALS BY SPECIALIST PHYSICIAN—When Members require a referral for additional care, PHYSICIAN will so notify the PacifiCare contracting Primary Care Physician that had referred the Member to Physician.

4.04 HOSPITAL ADMISSIONS—Whenever PHYSICIAN determines that a Member requires Hospital Services that are not Emergency Services, PHYSICIAN shall arrange for such hospital admission through PacifiCare and the Member's PacifiCare contracting Primary Care PHYSICIAN. PHYSICIAN shall not serve as the admitting Physician for the Member without prior approval of PacifiCare, except in the event that Emergency Services are required. If PHYSICIAN admits or refers a Member as an inpatient or an outpatient to a hospital for Emergency Services, Physician shall use their best efforts to notify PacifiCare and the Member's PacifiCare contracting Primary Care Physician of such admission within twenty-four (24) hours thereafter or on the first business day thereafter if such admission or referral

occurs on a weekend or holiday. Admissions for Emergency Services shall be made to Contracting Hospitals, if possible.

4.05 COLLECTION OF CHARGES FROM MEMBERS—PHYSICIAN shall collect applicable Copayments and deductibles from Members upon the rendition of service to Members pursuant to the PacifiCare Managed Care Plan. With the exception of Copayments and deductibles and charges for non-covered services delivered on a fee-for-service basis to Members, PHYSICIAN shall in no event including, but not limited to, non-payment by PacifiCare, insolvency of PacifiCare, or breach of this Agreement bill, charge, collect a deposit or attempt to bill, charge, collect, or receive any form of payment from any Member for Covered Medical Services provided pursuant to this Agreement.

A trust agreement has been established with the State based upon membership in order to assure payment to Providers only upon the condition of the HMO's insolvency.

PHYSICIAN shall not maintain any action at law or equity against a Member to collect sums owed by PacifiCare to Physician. Upon notice of any such charge, PacifiCare may terminate this Agreement and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges, including requiring PHYSICIAN to return all sums collected by PHYSICIAN as surcharges from Members or their representatives. Further, the term "surcharges" used herein shall not be defined or construed to mean, include, or encompass deductibles and/or Copayments duly earned by, due or owing to, PHYSICIAN for services rendered during the term of the Agreement. Nothing in this Agreement, however, shall be construed to prevent PHYSICIAN from providing non-covered medical services on a usual and customary fee-for-service basis to Members.

PHYSICIAN's obligations regarding the collection of charges from Members shall survive the termination of this Agreement with respect to Covered Services provided during the term of the Agreement without regard to cause of termination of the Agreement. Except as provided in Paragraph 7.03, these obligations shall not apply to services provided after the Agreement has been terminated.

4.06 COLLECTION OF CHARGES FROM THIRD PARTIES—PHYSICIAN accepts payment from PacifiCare for Medical Services as provided herein as full payment for such services; however, in the event of third- party liability, Worker's Compensation claims, or other primary insurance coverage, PHYSICIAN shall be entitled to all reimbursement received from such primary sources of payment for all Medical Services. In the event PHYSICIAN receives payment from such primary sources, PHYSICIAN shall reimburse PacifiCare any amounts paid by PacifiCare to Physician for such services within thirty (30) days after receiving payment from such primary sources. The amount reimbursed by PHYSICIAN to PacifiCare shall not exceed the amount initially paid by PacifiCare. Physician may collect and bill charges from third parties for COB, reinsurance and stop loss.

4.07 QUALITY ASSURANCE AND UTILIZATION REVIEW PROGRAMS - PHYSICIAN shall participate in and comply with the PacifiCare Quality Assurance Program and PacifiCare or its designated Utilization Review Organization. PHYSICIAN shall furnish such pertinent sections of a Member's medical records as may be required to implement said programs, at no cost to PacifiCare.

4.08 CAPACITY REPORTING—PHYSICIAN will provide to PacifiCare, at the earliest time possible, notice of any significant charges in the capacity of PHYSICIAN including a ninety (90) day written notice in the event

PHYSICIAN is unable or does not wish to serve additional Members.

4.09 RECIPROCITY AGREEMENTS—In the event PHYSICIAN provides Emergency or urgently needed Medical Services to Members, PHYSICIAN agrees to accept as payment for such Services the fees set forth in the schedule[Handwriten:*(s)* [*SEL 3/16/95*][*DS*] attached hereto as Attachment[Handwriten: *(s)]* A [Handwritten: *through H* [*SEL 3/16/95*][*DS*]] and incorporated herein by this reference.

4.10 OTHER CONTRACTUAL COMMITMENTS—PHYSICIAN represents and assures PacifiCare that other contractual commitments do not restrict or impair PHYSICIAN from performing its duties under this Agreement.

4.11 DISCLOSURE OF INFORMATION—PHYSICIAN agrees that PacifiCare may use PHYSICIAN's name, address, and telephone number in the Provider Directory during the term of this Agreement as an indication of PHYSICIAN's willingness to provide Medical Services to Members. Any other use of the PHYSICIAN's name in advertisements would be with the specific permission of said PHYSICIAN. Upon termination of this Agreement, PacifiCare agrees to remove PHYSICIAN's name from all future printings of marketing materials.

4.12 MEDICAL CARE CRITERIA—PHYSICIAN shall utilize the criteria for medical care that is established for approved by PacifiCare's Quality Assurance Program and the PacifiCare designated utilization review organization. The Utilization Review Committee is an PacifiCare Committee composed of PHYSICIANS with specialty physicians represented and chaired by a physician. When there is a dispute between a Primary Care Physician and the Specialty Consultant, the Committee will function in the role of advisor to the Primary Care Physician. If the specialist-proposed plan

for the patient is not endorsed and approved, another referral or course of action will be pursued, relieving the Primary Consultant of further responsibility. The Committee shall meet weekly and urgent approval can be obtained via telephone call to the Chairman or Committee member at any time. It is understood that disputes will be resolved in accordance with Section 9 of this Agreement.

4.13 NONDISCRIMINATION—PHYSICIAN represents and assures that it shall not discriminate between PacifiCare Members and its other patients due to race, sex, age, religion, place of residence, health status, or source of payment.

4.14 COMPLIANCE WITH CIVIL RIGHTS LAWS—PHYSICIAN shall comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975 as required by applicable laws or regulations.

5. DUTIES OF PACIFICARE

5.01 ADMINISTRATION—PacifiCare shall provide all administrative services under this Agreement, including quality assurance, utilization review, budgeting, administration of non-PCP claims, coordination of benefits, funds management and compliance with all Federal and State regulatory requirements.

5.02 BENEFIT INFORMATION—PacifiCare shall apprise all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under the PacifiCare Health Plan.

5.03 ASSIST PHYSICIAN—PacifiCare agrees to use its best effort to assist PHYSICIAN in the development and initial implementation of procedures necessary to carry out the terms of this Agreement.

5.04 ADMINISTRATION OF PAYMENTS—PacifiCare agrees to transmit payments to PHYSICIAN in accordance with the terms and procedures set forth in Section 6 herein.

6. COMPENSATION

6.01 CAPITATION PAYMENTS TO PCPs - PacifiCare shall make monthly Capitation Payments or other agreed upon payments to PCP as set forth in Attachment B for each Member on PCP's Eligibility List, as complete compensation for PCP's responsibilities described herein, except for applicable Copayments.

6.01.01 CAPITATION ADJUSTMENTS - The Capitation Payment shall be subject to retroactive adjustments by PacifiCare based upon subsequent eligibility determinations of Members, and collection of billed premiums, calculation errors, or computer system errors. Such retroactive adjustments shall be limited to ninety (90) days after the end of the month for which the applicable Capitation Payment applies. [Handwritten: *The PCP will be paid for the full and entire month for each Member even if the Member is under the responsibility of the PCP for a portion, or any portion of the month.* [*SEL 3/16/__*] [*DS*]]

6.02 PAYMENT DUE DATE - if applicable Monthly Capitation Payments shall be payable by PacifiCare to PCP by the fifteenth (15) day of the month for the current month's Covered Services.

6.03 COORDINATION OF BENEFITS - Provider shall follow the procedures set forth in the PacifiCare Provider Policies and Procedures Manual in coordinating benefits.

6.04 COMPENSATION TERMS: METHODS OF PAYMENT TO SPECIALIST - With the exception of any applicable Copayments and deductibles, which may be

properly charged to the Member, PacifiCare shall pay within thirty (30) days of receipt of a properly filed claim, compensation to PHYSICIAN for Covered Medical Services provided by PHYSICIAN in accordance with the terms and conditions set forth as Exhibit A and incorporated herein by this reference. [Handwritten: *A properly completed ("clean") standard HCFA 1500 or successor AMA (American Medical Association) approved claim form will be acceptable by PacifiCare.* [*SEL 3/16/95*] [*DS*]] PHYSICIAN shall accept such payment as complete compensation for PHYSICIAN's responsibilities described herein (except as to applicable Copayments and non-covered services, as provided in Section 3.05 above). In the event it is retroactively determined that a Member is not covered under the PacifiCare Managed Care Plan, PacifiCare shall not retroactively deduct from payments to PHYSICIAN any amount for the provision of Covered Services rendered to said Member. However, PacifiCare may deduct from future payments to PHYSICIAN amounts based on the provision of non-covered services to Members with prior notice. If PHYSICIAN receives payment from another source for services rendered to a Member retroactively determined ineligible, PHYSICIAN shall reimburse PacifiCare the amount PHYSICIAN received from PacifiCare.

6.05 ADEQUACY OF COMPENSATION—PHYSICIAN shall accept the fee-for-service payments from PacifiCare specified herein (plus applicable Copayments) as payment in full for all Medical Services actually provided Members. PHYSICIAN shall make its best effort to submit all bills for Medical Services rendered to Members within thirty (30) days after such services are rendered or at least within an absolute limit of one hundred eighty (180) days for the first ~~six (6)~~ [Handwritten: *twelve (12)* [*SEL 3/16/95*] [*DS*]] months and thereafter within an absolute limit of ~~ninety (90)~~ [Handwriten: *one hundred twenty (120)* [*SEL 3/16/__*]

[*DS*]] days. Regardless of the financial condition of PHYSICIAN during the term of this Agreement, PHYSICIAN shall continue to provide care to Members as provided in this Agreement. Charges by PHYSICIAN to Members for Covered Services rendered by PHYSICIAN are prohibited; upon notice of the existence of any such charge (other than Copayments), PacifiCare shall take appropriate action consistent with the terms of this Agreement to eliminate such charges.

7. TERM OF AGREEMENT

7.01 TERM—The initial term of this Agreement shall commence on April 1, 1995 (the "Commencement Date") and shall continue for a period of one (1) year. The term of this Agreement shall be automatically extended for one (1) additional year on each successive anniversary of the Commencement Date of this Agreement, unless terminated by either party as provided in Section 7 below. Each one (1) additional year of automatic extension, the then applicable rates of compensation specified in this Agreement shall apply unless otherwise agreed upon by the parties in writing.

8. TERMINATION

8.01 TERMINATION WITHOUT CAUSE—This Agreement may be terminated without cause by either party by providing ninety (90) days prior written notice to the other party. If the Agreement is terminated by PHYSICIAN pursuant to this Section 7.01, PHYSICIAN shall also provide sixty (60) days prior written notice to the Florida Department of Insurance.

8.02 TERMINATION OF AGREEMENT WITH MATERIAL CAUSE—PacifiCare may terminate this Agreement by giving PHYSICIAN thirty (30) days prior written notice in the event of any material breach by

PHYSICIAN of any term of this Agreement. PacifiCare's written Notice of Termination shall state the circumstances constituting cause for termination. PHYSICIAN shall have thirty (30) days from the receipt of such notice to cure or otherwise eliminate the circumstances constituting the cause for termination. If PHYSICIAN fails to cure or eliminate such circumstances within the thirty (30) day notice period, this Agreement shall terminate at the end of such notice period.

8.03 IMMEDIATE TERMINATION—This Agreement may be terminated immediately by PacifiCare in the event of (a) loss of licensure by PHYSICIAN or (b) a determination by PacifiCare, based on reasonable evidence, that the health and well being of Members is jeopardized as the result of continuation of this Agreement. PHYSICIAN may appeal termination by availing him(her)self of the appeals process spelled out in the PacifiCare Provider Policy and Procedures Manual.

8.04 REPAYMENT UPON TERMINATION—Within one hundred and ~~eighty~~ [Handwritten: *twenty* [*SEL 3/16/95*][*DS*]] (120) days following termination of this Agreement, an accounting shall be made of monies due and owing either party and payment shall be forthcoming to settle such balance within thirty (30) days following such accounting.

8.05 CANCELLATION OF AGREEMENT—This Agreement shall be canceled upon issuance of an order by the Florida Department of Insurance pursuant to Section 641.234(3) of the Florida Insurance Code.

8.06 CONTINUING CARE RESPONSIBILITIES—In the event of termination of this Agreement, PCP or Specialists shall continue to be responsible for providing Primary Care Services and arranging Referral Services under the terms of this Agreement to Members on PCP's or

Specialist's Eligibility List during the phase-out period. The phase-out period shall mean the period beginning the termination date of the Agreement and ending the earlier of: (a) the expiration of three (3) months from the date of termination of this Agreement or (b) the effective date of the commencement of services by another contracting primary care physician practicing in the same geographic area and who can effectively provide primary care services to the affected Members. However, if alternate care cannot be arranged for the Member prior to the expiration of the phase-out period for the reason of continuity of care or other medical treatment reasons, PHYSICIAN shall continue to treat Member until PacifiCare has made provision for such alternate care and has notified PHYSICIAN of such in writing. Payment for any continued Primary Care Services provided during or following the phase-out period shall be at the standard fee schedule as described in the attachments for the appropriate Health Plan Services or Products.

Notwithstanding the above or any other provisions to the contrary, PHYSICIAN agrees that in the event PacifiCare ceases operations for any reason, including insolvency, PHYSICIAN shall provide or arrange Covered Services and shall not bill, charge, collect, or receive any form of payment from any Member or have recourse against a Member for Covered Services provided after PacifiCare ceases operations. This continuation of Covered Services obligation shall be for the period for which Health Plan Premiums have been paid, not to exceed a period of thirty (30) days, except for those Members who are hospitalized on an inpatient basis as provided below. In the event PHYSICIAN terminates this Agreement on the basis of PacifiCare's failure to make timely Capitation Payments or PacifiCare ceases operations, PHYSICIAN shall continue to arrange for Covered Services to those Members who are hospitalized on an inpatient basis at the time PacifiCare ceases operations or at the time of

termination of this Agreement until such Members are discharged from the hospital.

PHYSICIAN agrees that the provisions of this Section 7.06 and PHYSICIAN's obligations herein shall survive the termination of this Agreement without regard to the cause for termination of the Agreement and shall be construed to be for the benefit of the Members.

9. RECORDS, DATA COLLECTION, CITATIONS, AND RIGHT TO INSPECT

9.01 MAINTENANCE OF RECORDS—PHYSICIAN shall maintain records and information as reasonably necessary for PacifiCare to properly administer the PacifiCare Health Plan and consistent with state and federal law. PHYSICIAN shall maintain books and records of account for all financial transactions pertaining to the delivery of Covered Services to Members, in accordance with general standards for book and record keeping. PHYSICIAN shall maintain all patient medical records relating to Medical Services provided to members, in such form and containing such information as required by applicable state law (and in accordance with the usual and customary practices in the United States), including, without limitation, medical histories, medical charts, records and reports from Specialist Physicians and other providers of Referral Services, hospital discharge summaries, records of Emergency Services and any records necessary to disclose the quality, quantity, appropriateness and timeliness of Covered Services provided to Members under this Agreement.

9.02 PROVISION OF RECORDS—PHYSICIAN shall maintain and provided [Handwritten: [*SEL 3/16/95*] [*DS*]] such records and information to PacifiCare, the NCQA, the AHCA, or the Florida Department of Insurance as may be necessary for compliance by PacifiCare with the provisions of state and federal law and regulations promulgated thereto.

Such records shall be retained by PHYSICIAN for at least five (5) years following the provision of Covered Services. The obligations created by Sections 8.01 and 8.02 shall not terminate upon the termination of this Agreement regardless of the cause giving rise to such termination. Further, upon request with approved patient consent, PHYSICIAN shall provide a copy of all or part of a Members medical record to PacifiCare at no cost as necessary to resolve billing, service, clinical, quality or utilization issues within three (3) business days.

9.03 CONFIDENTIALITY OF RECORDS—PHYSICIAN shall maintain the confidentiality of all Member medical records and treatment information in accordance with all applicable state and federal laws. Where required by law, PHYSICIAN shall obtain specific written authorization from Member prior to releasing Member's medical records.

PHYSICIAN shall establish and maintain procedures and safeguards so that no information pertaining to Members contained in PHYSICIAN's records or obtained from the Florida Department of Insurance or AHCA in carrying out the terms of this Agreement shall be used or disclosed by PHYSICIAN or its agents, officers or employees other than for purposed directly connected with the administration of the PacifiCare Health Plan, or except as provided in Section 1106 of the Social Security Act, as amended, and the regulations promulgated thereunder.

9.04 RIGHT TO INSPECT OR AUDIT—SWFPHO shall provide access at reasonable times upon demand by PacifiCare, the NCQA or any other accreditation organization, the Florida Department of Insurance, the AHCA, or any other governmental regulatory agency responsible for the administration of health care services plans, to periodically audit or inspect the facilities, equipment, books, documents and records relating to the performance of this Agreement including, without limitation,

all phases of professional and ancillary medical care provided or arranged for (subject to the confidentiality restrictions set forth in Section 8.03 and the professional and legal standards applicable to the PHYSICIAN-patient relationship), and financial records pertaining to the cost of operations and income received by PCP for Medical Services rendered to Members. Unless otherwise required by law, PacifiCare shall provide PCP with a forty-eight (48) hour prior written notice of any such inspection or audit. Further, PCP shall comply with any requirements or directives issued by PacifiCare, the NCQA, the AHCA or other governmental authorities as a result of such evaluation, inspection or audit of PCP.

9.05 ENCOUNTER DATA COLLECTION—PCP shall maintain and provide to PacifiCare, on or before the fifteenth (15th) day of each month for the Covered Services provided the previous month, the utilization and encounter data more particularly described in the Provider Policies and Procedures Manual, for the effective management of PacifiCare's Health Plans, as well as any other data required by state or federal law.

9.06 TRANSFER OF MEDICAL RECORDS UPON TERMINATION—Upon the effective date of termination of this Agreement and, if applicable, upon the expiration of the phase-out period of any continuing care obligations, and at PacifiCare's and/or the Member's request, PHYSICIAN shall copy all active Member patient medical files in PHYSICIAN's possession and forward such files to another provider of Medical Services designated by PacifiCare, provided such copying and forwarding is not otherwise objected to by such Members. The copies of such medical files may be in summary form. The cost of copying the patient medical files shall be borne solely by terminating party. PHYSICIAN shall cooperate with PacifiCare in maintaining the confidentiality of such Member medical records at all times.

10. GOVERNING LAW, GRIEVANCE PROCEDURE AND ARBITRATION

10.01 GOVERNING LAW—This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Florida and the United States of America, including, without limitation, the Florida Health Maintenance Organization Act, as amended, and the regulations promulgated thereunder by the Florida Department of Insurance. Any provisions required to be in this Agreement by state or federal law or regulations shall bind PacifiCare and PHYSICIAN whether or not expressly provided in this Agreement.

10.02 MEMBER GRIEVANCES—PacifiCare shall be responsible for resolving Member claims for benefits under the PacifiCare Health Plan and all other claims against PacifiCare. PacifiCare shall resolve such claims utilizing the grievance resolution procedures set forth in the PacifiCare Health Plan and included in the PacifiCare Policies and Procedures Manual.

PHYSICIAN shall assist PacifiCare in the handling of such Member grievance, consistent with the terms of the PacifiCare grievance resolution procedures. In the event an oral or written grievance is presented to PHYSICIAN relating to benefits or coverage under the PacifiCare Health Plan, PHYSICIAN will immediately deliver such grievance to PacifiCare for handling pursuant to the PacifiCare grievance resolution procedures.

PHYSICIAN shall comply with all final determinations made by PacifiCare through the grievance resolution procedure. PacifiCare and PHYSICIAN shall collaborate and cooperate in the investigation and resolution of complaints and grievances that may arise in connection with PHYSICIAN. PHYSICIAN shall submit monthly reports to

PacifiCare for all Medicaid member complaints received by PHYSICIAN, which includes Member name and PacifiCare identification number, date of complaint, nature of complaint, and resolution and date of resolution of complaint.

10.03 ARBITRATION—Any controversy or claim arising out of, or relating to, this Agreement, or the breach thereof, or with respect to any of the documents executed in conjunction herewith, that cannot be resolved through the PacifiCare Provider Grievance Process as spelled out in the PacifiCare Provider Policy and Procedure Manual or that cannot be resolved using the state of Florida's Benefit and Payment Policy, shall be settled by Arbitration in accordance with the commercial rules of the American Arbitration Association. Such arbitration shall occur in Lee County, Florida, unless the parties mutually agree to have such proceeding in some other locale. Civil discovery shall be permitted under the term of Florida law.

Upon submission of a dispute to the American Arbitration Association, PacifiCare and PHYSICIAN agree to be bound by the rules of procedure and decision of the American Arbitration Association. The arbitrator shall have the power to grant all legal and equitable remedies and award compensatory damages provided by Florida law, but shall not have the power to award punitive damages. The arbitrator shall prepare in writing and provide the parties an award including factual findings and the legal basis and other reasons on which the award is based. The arbitrator shall not have the power to commit errors of law or legal reasoning. Judgment upon the award rendered may be entered in any court having jurisdiction thereof.

10.04 DISPUTES BETWEEN PHYSICIAN AND MEMBER NOT GOVERNED BY AGREEMENT—Any controversies or claims between PHYSICIAN and Member arising out of PHYSICIAN's performance of this Agreement are not governed by this Agreement. PHYSICIAN and

Member may seek any appropriate or legal action to resolve such controversy or claim deemed necessary. In the event of dispute (not involving professional malpractice) between PHYSICIAN and Member, and upon mutual agreement between PHYSICIAN and the Member, PacifiCare agrees to make available the grievance resolution process described in the applicable Member Agreement for resolution of such dispute provided at the time of contracting. In such instance, the decision of the Member Satisfaction Committee and Board of Trustees shall not be binding upon the parties except upon agreement between PHYSICIAN and Member. Nor shall such grievance be subject to binding arbitration except upon agreement between the parties. Should PHYSICIAN and Member fail to resolve the grievance, PHYSICIAN and Member may seek any appropriate legal action deemed necessary by such party. [Handwritten: *The venue and location for such proceedings shall be in Lee County, Florida, unless both parties agree to have such proceeding in some other locale.* [*SEL 3/16/95*] [*DS*]]

11. NOTICE

11.01 NOTICE—Any notice required to be given hereunder shall be in writing, registered or certified mail, return receipt requested, to either PacifiCare or PHYSICIAN at the addresses listed below or at such other addresses as either PacifiCare or PHYSICIAN may hereafter designate to the other:

To PacifiCare:

PacifiCare of Florida, Inc.
One Alhambra Plaza
Suite 1000, Tenth Floor
Coral Gables, Florida 33134
ATT: General Manager, South Florida

To ~~PHYSICIAN~~: _____

[Handwritten: *PHO* [DS]] _____

_____

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

12. MISCELLANEOUS

12.01 CONFIDENTIAL AND PROPRIETARY INFORMATION—PHYSICIAN agrees to maintain confidential (the "Confidential Information"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of Members which has been compiled by PacifiCare; (b) PacifiCare's administrative service manuals and all forms related thereto; (c) PacifiCare of Florida contracts and the information contained therein; (d) the financial arrangements between PacifiCare and any PacifiCare contracting provider; and (e) any other information compiled or created by PacifiCare which is proprietary to PacifiCare and which PacifiCare identifies as proprietary to PHYSICIAN in writing. PHYSICIAN shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. PHYSICIAN may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of PacifiCare. Upon the effective date of termination of this Agreement, PHYSICIAN shall promptly return to PacifiCare the Confidential Information in

his/her possession. The provisions of this section shall not apply to PacifiCare information that is in the public domain.

12.02 SOLICITATION OF PACIFICARE MEMBERS.

12.03 CONFIDENTIALITY OF THIS AGREEMENT—Each party agrees to maintain the terms of this Agreement confidential. Disclosure of the terms of the Agreement shall not be made without the approval of the other party.

12.04 ASSIGNMENT—This Agreement shall not be assigned by PHYSICIAN without the prior written consent of PacifiCare. PacifiCare reserves the right to assign, sell or transfer this agreement to any successor organization or affiliate of PacifiCare.

12.05 INVALIDITY OF SECTIONS—The unenforceability or invalidity of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement

12.06 ATTORNEY'S FEES—If any action at law or suit in equity or arbitration is brought to enforce or interpret the provisions of this Agreement or to collect any monies due hereunder, the prevailing party shall be entitled to reasonable attorneys' fees and reasonable costs, together with interest thereon at the highest rate provided by law, in addition to any and all other relief to which it may otherwise be entitled.

12.07 AMENDMENT—PacifiCare may amend this Agreement by providing thirty (30) days prior written notice via Registered or Certified mail, return receipt requested to PHO. Such amendment shall be binding upon PHO unless PHO provides notice of objection to PacifiCare within the thirty (30) day notice period. If PHO provides such notice of objection within the 30-day notice period, the amendment shall not be effective until the parties amend the Agreement through a written amendment signed by both parties.

12.08 INCORPORATION OF EXHIBITS—All exhibits and attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

[Handwritten:

NOTICES: Notices to PacifiCare shall be sent to ONE ALAHAMBRA PLAZA, Suite 1000, Coral Gables, FL 33134, unless changed in writing with 30 days notice. Notices to PHO shall be sent to Southwest Florida Physician Hospital Organization (SWFPHO) c/o SWFRMC 2727 WINKLER AVE., Ft Myers, FL 33901, unless changed in writing with 30 days notice. [SEL 3/15/95] [DS]]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement

	[Handwritten: *PHYSICIAN HOSPITAL ORGANIZATION (PHO)]*
PACIFICARE OF FLORIDA, INC.	~~PACIFICARE OF FLORIDA, INC.~~
BY: /s/	BY: /s/
TITLE: [Handwritten: *Vice President, Planning Development*]	TITLE: [Handwritten: *Steven E. Levine, M.D.*]
DATE: [Handwritten: *3/17/95*]	DATE: [Handwritten: *3/16/95*]

~~TAX ID#~~ [Handwritten: *TITLE*]: [Handwritten: *Chairman, SWFPHO*]

SUTTER HEALTH

AND

PACIFICARE OF CALIFORNIA

TERM SHEET

Sutter Health and PacifiCare of California
Term Sheet

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Sutter Health and
PacifiCare of California

TERM SHEET

This Term Sheet is entered into by and between PacifiCare of California ("PacifiCare") and Sutter Health ("Sutter") on behalf of the Providers listed in Exhibit A. (Sutter and PacifiCare are sometimes referred to collectively as the "Parties").

Recitals

A. Sutter is the parent corporation for all of the Hospital and Medical Foundation Providers listed on Exhibit A and is duly authorized to negotiate and contract on their behalf. Sutter is also the duly authorized attorney-in-fact for those IPAs listed on Exhibit A, except for those IPAs which are subcontracted to a Sutter affiliated Medical Foundation.

B. Subject to Section 3.1.1., below, PacifiCare has existing provider contracts with the Providers listed on Exhibit A (these contracts are individually or collectively referred to as "Provider Contract(s)" or "Provider Services Agreements). The purpose of this Term Sheet is to memorialize the material financial and business terms pursuant to which those Providers listed in Exhibit H will rescind their termination notices and all Providers will continue their contractual relationships with PacifiCare for 2000.

Definitions

1. *Hospital* refers to the Hospitals listed in Exhibit A.

2. *Medical Group* refers to the Medical Foundations and IPAs listed in Exhibit A.

3. *PacifiCare* references any organization owned in whole or part by PacifiCare, its successors, or any

organization which, by contract or other agreement, benefits from any provision of this Term Sheet in the same manner as PacifiCare might benefit.

4. *Provider(s).* For purposes of this Term Sheet only, Provider(s) refers to any of the hospitals, medical foundations and/or aligned IPA's listed on Exhibit A. The use of this definition in this Term Sheet is for convenience only and shall not change the definition of Provider(s) in any of the underlying Provider Contracts.

Article 1

Rates

1.1 *FFS Rates.* PacifiCare shall compensate Providers listed in Exhibit A at the FFS rates and according to the terms set forth in Exhibit B.

1.2 *Medicare Risk Rates.* PacifiCare shall compensate capitated Providers at the rates set forth in Exhibit C and according to the terms set forth in that Exhibit and in Article II below.

Article 2

Terms Related to Medicare Risk Arrangements

2.1 *Pharmacy Risk/Pharmacy Management.* Any pharmacy risk or deficit-sharing arrangement in place with PacifiCare and Provider is terminated as of December 31, 1999. A new Pharmacy Management Program is effective January 1, 2000 and outlined in Exhibit G.

2.2 *Encounter Data.* Provider shall provide to PacifiCare all encounter data in a timely manner and accurate form as required by HCFA regulations and PacifiCare policy. PacifiCare will accept the responsibility for remitting Provider encounter data to HCFA correctly, accurately and timely, and PacifiCare will agree to

indemnify Provider from any material adverse financial impact due to PacifiCare's gross negligence or significant administrative failure.

2.3 *Investigational/Experimental.* PacifiCare does not consider Investigational and experimental procedures covered services. PacifiCare shall be responsible for treatment deemed investigational or experimental when PacifiCare gives approval for such services, except when Investigational/Experimental procedures are reviewed by an external review board and deemed medically necessary by the external review board. In cases deemed medically necessary by the external review board, they become covered services and are the financial responsibility of Medical Group and Hospital.

2.4 *The Division of Financial Responsibility (DOFR).* The DOFR attached at Exhibit D shall be effective January 1, 2000 for all Medicare Risk capitated Providers. Subject to Section C.7 in Exhibit C, PacifiCare shall not change the DOFR attached as Exhibit D without the written consent of Sutter.

2.5 *Low Enrollment Guarantee.*

2.6 *Services to Non-Members.* In the event services are provided to an individual who is not a Member who Provider believed to be a Member based on erroneous or delayed enrollment lists or confirmation of enrollment by PacifiCare, PacifiCare shall be financially liable for all such services provided by Provider prior to the time Provider received notice of that person's ineligibility provided, however, this Section will not apply when Medicare is the primary payor. Additionally, capitation received from another Medicare risk health plan shall be deemed payment. Provider will make best effort attempts, but not more than two

billing cycles, to collect the monies due for such services from the individual or its other coverage prior to billing PacifiCare.

Article 3

General Provisions

3.1 *Provider Contracts.* This Term Sheet constitutes an amendment of each of the underlying agreements between PacifiCare and each Provider with respect to Medicare programs, except for SDMC, SSMC, and EMC, where certain changes pertain to the Commercial program, and no other documents are required in order for the provisions in this Term Sheet to be effective. All terms in the Provider Contracts not modified by this Term Sheet shall remain unchanged and in full force and effect. Each Hospital and/or Medical Group hereby recinds the termination of the underlying documents as referenced in Exhibit H.

3.1.1 *MPMC/MPMG/PAMF/SMCSR/SMFNB and Provider Agreements.* Except to the extent modified by this Term Sheet, MPMC and SMCSR shall be bound by the terms set forth in the current SMCS Provider Agreement as if in each case the applicable Sutter Provider and PacifiCare had signed a separate provider agreement in the applicable form. Except to the extent modified by this Term Sheet, MPMG, SMFNB and PAMF shall be bound by the terms set forth in the current SMF Provider Agreement as if in each case the applicable Sutter Provider and PacifiCare had signed a separate provider agreement in the applicable form. Each of these agreements shall be considered a "Provider Contract" for purposes of this Term Sheet.

3.1.2 *ABMC.* With respect to both commercial and Medicare products, ABMC shall only accept capitation for, and be financially liable for providing services to, Members linked to ABMG. Sutter and PacifiCare agree to work in good faith to execute a Provider agreement to replace the existing underlying letter of agreement for ABMC and ABMG by January 31, 2000.

3.2 *Further Negotiations/New Provider Contracts.* The Parties agree to meet and confer in good faith and use best efforts to finalize the terms and conditions of the Provider Contracts by April 1, 2000. The new capitated and fee for service Provider Contracts will be on PacifiCare's model contract form to be negotiated by the Parties. That form shall include the terms of this Term Sheet and only such additional terms as the Parties agree are necessary to implement this Term Sheet; provided, however, that the failure to complete such Provider Contracts shall not affect the binding nature of this Term Sheet.

3.3 *Hierarchy of Provisions.* The PacifiCare Policy and Procedure Manual and Benefits Manual ("Manuals") shall not be used to invalidate the provisions of this Term Sheet or the Provider's individual contract. This Term Sheet will supercede conflicting provisions of the Provider's individual contract with respect to Medicare programs, except for SDMC, SSMC, and EMC, where certain changes pertain to the Commercial program. The terms of those individual contracts and this Term Sheet shall supercede conflicting terms in the Manuals.

3.4 *Material Changes.* In the event of a change(s) in the cost of contracted services, including administrative services, that has a Material financial impact (as

defined below) on a Provider who is financially at risk for such services or on a shared risk pool due to a) changes in Federal or state regulations; b) advances in technology net of improved health care cost benefit or changes in generally accepted patient care guidelines including treatment and disease prevention plans; c) increased pricing for pharmaceutical or chemotherapy drugs; or d) changes in benefit structures or plan types, either Party may initiate the following process:

3.4.1 The Parties shall promptly meet and confer for a period not to exceed thirty (30) days' to determine if the change is Material (based on the definition set forth below) and whether and to what extent the rates set forth in the Provider Contract, including the rates in this Term Sheet, need to be modified to reflect how the Parties shall address the changed cost.

3.4.2 If the Parties cannot agree that the change is material or as to the amount of the change, PacifiCare will be financially liable for such increased costs, or credited for such reduced costs as determined by an independent actuary mutually agreed to and paid by the Parties.

3.4.3 For purposes of this Section, a change is Material if there is a financial impact on the Provider at risk of at least $1.00 pmpm.

3.4.4 This term shall only apply to Medicare programs.

3.5 *SIP Assignment.* The Sutter Independent Physicians (SIP) PacifiCare Provider agreement(s) for all products are assignable to SMF with thirty (30) days' written notice to PacifiCare by SIP, which notice shall include SMF's written agreement to assume such agreements.

3.6 *Affiliate Specific Information.* If Plan intends to publish or release to any third party, including Members, any Provider—specific information or data regarding health outcomes or treatment plans/needs, or data comparing Providers to each other or to any other health care Providers, Plan shall use its best efforts to provide copies of such information to Sutter and the affected Provider at least ninety (90) days' prior to publication or release. Provider shall then have thirty (30) days' to verify the accuracy of that information and, if necessary, provide corrected information to Plan, in which case Plan shall use the corrected information in place of the information originally intended. If the Parties cannot agree on accurate information within thirty (30) days' of the date Provider gives corrected information to Plan, Plan may publish its original information at the end of the ninety (90) day period, provided it will make best efforts to include a notice with that information that Provider disputes the accuracy of the information being published. If either Party cannot meet the timeframe(s) described above, they shall still attempt to exchange the information described and do their best to comply with the spirit of this section.

3.7 *Plan Merger.* In the event that PacifiCare is purchased by, purchases or merges with another entity ("NEWCO") (which transaction is referred to as a "merger" for purposes of this Section), the terms of this Term Sheet shall be binding on the surviving organization (whether PacifiCare or NEWCO) as to any and all PacifiCare Members who were enrolled in an PacifiCare product which is or was subject to this Term Sheet prior to the merger ("PacifiCare Product"), for so long as the PacifiCare Member continues to be enrolled in the PacifiCare product. The Parties further agree that as to any PacifiCare

Member enrolled in an PacifiCare Product, the reimbursement due Providers and other applicable terms shall be as set forth in this Term Sheet for as long as the PacifiCare Member is enrolled in that PacifiCare Product. Furthermore, NEWCO Members shall not be entitled to access the rates in this Term Sheet unless NEWCO Members become enrolled in a PacifiCare Product.

3.8 *Confidentiality.* PacifiCare and Sutter agree to hold in confidence all confidential or proprietary information or trade secrets in confidence including, specifically, the terms of this Term Sheet. Both Parties shall not disclose confidential information without the prior written consent of the other Party.

3.9 *Facility/PPG Risk Arrangements.* The Parties acknowledge that a number of laws and regulations impose certain obligations on PacifiCare with respect to what have traditionally been referred to as "risk sharing arrangements," but which Sutter affiliates now refer to as "care management agreements and/or quality incentive plans (collectively referred to as "incentive arrangements"). If a Facility/Hospital Provider has an incentive arrangement with Medical Group or IPA, it shall notify PacifiCare that such an agreement(s) exists and, upon request, shall provide PacifiCare with all information PacifiCare needs to allow it to comply with Physician Incentive Plan laws and regulations.

3.10 *Interest.* Any amounts due and payable but unpaid as of their due date are subject to the legally permissible interest rate as it pertains to FFS reimbursement.

3.11 *Assignment.* Except as provided in Section 3.5, neither Party may assign rights or delegate duties identified in this Agreement without the prior written consent of the other Party.

3.12 *Effective Date/Term.* The Parties have agreed that the rates set forth in this Term Sheet as well as the terms of the existing Provider Contracts shall commence on January 1, 2000 and shall continue for a period of twelve (12) months not to extend beyond December 31, 2000, unless both Parties mutually agree in writing to extend the term. The Term Sheet and the existing Provider Contracts cannot be terminated by either party without cause, prior to December 31, 2000. The Parties agree to meet at least 120 days prior to December 31, 2000 to discuss a new agreement to be effective January 1, 2001. If any Provider has a continuing care obligation under any Provider Contract covered by this Term Sheet, PacifiCare shall pay for any services provided after December 31, 2000 at 100% of Billed Charges for the Commercial product and 100% of Medicare allowables for the Medicare Risk product.

3.13 *Waiver.* Any failure of a Party to insist upon strict compliance with any term, undertaking or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be in writing, signed and dated by the Parties.

3.14 *Recitals and Exhibits.* The recitals and exhibits are hereby incorporated into this Agreement by this reference.

3.15 *Governing Law.* This Agreement shall be governed by and construed in accordance with the laws of the State of California.

3.16 *Ambiguities.* This Agreement has been negotiated at arm's length and among Parties sophisticated and knowledgeable in the matters dealt with in this Agreement. In addition, each Party has been advised

by experienced and knowledgeable legal counsel. Accordingly, any rule of law (including but not limited to California Civil Code 1654) or legal decision that would require interpretation of any ambiguities in this Agreement against the Party that has drafted it is not applicable and is waived. The provisions of this Agreement shall be interpreted in a reasonable manner to effect the purpose of the Parties.

3.17 *Severance/Effect.* In the event any provisions of this Agreement is declared void by a court or arbitrator, or rendered invalid by any law or regulation, such portion shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to materially change the substance of the economic relationship created by this Agreement, or to place a Party in material violation of its articles of incorporation or bylaws, in which case, the Agreement may be immediately terminated by either Party.

3.18 *Force Majeure.* In the event of a major disaster, earthquake, epidemic, complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of Provider's personnel, or similar or dissimilar causes not reasonably within the control of Provider, then:

a. If such event delays or makes impractical the rendition of Covered Services pursuant to this Agreement, the affected Provider shall not be liable for any damages resulting from its delay or failure to provide Covered Service; and,

b. Capitation reimbursement shall stop on the first of the month following the event, and shall not be paid until such time as the Provider provides written notice that it is again

able to provide Covered Services. Provider shall be paid the fee-for-service rates applicable in this Agreement.

c. If Medical Group or Hospital is permanently unable to provide a substantial portion of the Covered Services which it has agreed to provide due to such circumstances, Medical Group or Hospital shall have the right to terminate this Agreement upon ten (10) days' written notice.

The Parties shall resolve how to handle labor disruptions as part of the future negotiations described in Section 3.2.

3.19 *Dispute Resolution.* Disputes and breaches of contract will be resolved in accordance with Exhibit E. The California law governing the statute of limitations for claims brought under this Agreement shall apply in all cases.

3.20 *Notices.* Any notice required or desired to be given under this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage pre-paid, or overnight courier, addressed as follows:

Sutter Health Attn: Sr. Vice President, Managed Care P.O. Box 160727 Sacramento, CA 95814	PacifiCare of California Attn: President 5470 Plaza Drive Cypress, CA 98630

3.21 *Execution.* By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the Party(ies) on whose behalf their execution is made.

SUTTER HEALTH, on it's own behalf, on behalf of its affiliated Hospitals, Medical Foundations and as Attorney-in-Fact for the IPA Providers	PACIFICARE OF CALIFORNIA
/s/	/s/
Signature	Signature
[Handwritten: *Snr. VP*]	[Handwritten: *President, Northern Calif.*]
Title	Title
[Handwritten: *1/16/00*]	[Handwritten: *1-13-00*]
Date	Date

Exhibit A

Participating Providers

A.1 *Tertiary Facilities*

- Sutter Medical Center, Sacramento which includes: Sutter Memorial Hospital, Sutter General Hospital and Sutter Center for Psychiatry (SMCS)
- Alta Bates Medical Center (ABMC)
- Mills-Peninsula Medical Center (MPMC)
- Marin General Hospital (MGH)
- Memorial Hospitals Association (MHA)—Memorial Medical Center—Modesto

A.2 *Acute Facilities* (Acute facilities can and do provide certain tertiary services):

- Eden Medical Center (EMC)
- Memorial Hospital Los Banos (MHLB)
- Novato Community Hospital (NCH)
- Sutter Auburn Faith Hospital (SAFH)
- Sutter Davis Hospital (SDH)
- Sutter Delta Medical Center (SDMC)
- Sutter Medical Center of Santa Rosa (SMCSR)
- Sutter Roseville Medical Center (SRMC)
- Sutter Solano Medical Center (SSMC)
- Sutter Tracy Community Hospital (STCH)

A.3 *Medical Foundations*

- Sutter Medical Foundation (SMF)
  Sutter Medical Group (SMG)
- Sutter Medical Foundation—North Bay (SMFNB)
  Sutter Medical Group of the Redwoods (SMGR)
- Sutter Gould Medical Foundation (SGMF)

- Palo Alto Medical Foundation (PAMF) (See Section C.2 regarding contingency.)
  Palo Alto Medical Clinic (PAMC)

A.4 *IPAs*

- Mills-Peninsula Medical Group (MPMG)
- Alta Bates Medical Group (ABMG)
- Marin IPA (MIPA)
- Central Valley Medical Group (Sub-contracted to SGMF in Stanislaus county) (CVMG)
- Sutter Independent Physicians (SIP)

Exhibit E

Dispute Resolution Process

E.1 *Meet and Confer.* The Parties agree to meet and confer to settle all disputes within thirty (30) days' of written request by either Party. Representatives of the Parties with authority to settle dispute will meet at least once prior to pursuing mediation and/or arbitration. If the Parties cannot agree, they may choose to use mediation as a dispute resolution tool. In this event, Section E.2 shall apply. All discussions held pursuant to this Section E.1 and Section E.2, if applicable, will be for settlement purposes only and subject to confidentiality and non-disclosure agreements which shall be signed by both Parties.

E.2 *Mediation.* The entire mediation process shall be confidential and the privileges and protection of Evidence Code Section 1152.5 shall apply. Prior to commencement of mediation, if requested by either Party or the mediator, the Parties and the mediator shall execute a written confidentiality agreement in accordance with the provisions of Evidence Code Section 1152.5.

If the Parties are unable to resolve the dispute through the meet and confer process, it shall be submitted to mediation before a mediator who will be selected within sixty (60) days' from the last meet and confer (a) by mutual agreement between the Parties, or (b) if the Parties are unable to agree, in accordance with the procedures of JAMS/Endispute. Mediation shall proceed and continue until the earlier of sixty (60) days' after commencement or such time as the dispute is either resolved or the mediator or the Parties agree that mediation should not continue.

At the mediation, each Party shall be represented by persons with authority to negotiate a resolution of the dispute, and may be represented by counsel. The mediator shall determine the format for the meetings. The mediation session shall be private. The entire mediation process shall be confidential and the privileges and protection of Evidence Code Section 1152.5 shall apply.

The fees and expenses of the mediator shall be borne equally by the Parties. All fees, costs and expenses of the mediator and mediation facilities shall be borne equally by the Parties, and all fees, costs and expenses of each Party other than those for the mediator and/or mediation facilities shall be borne and paid for by the Party who incurs them.

E.3 *Arbitration*. Any controversy, dispute or claim arising out of this Agreement which is not resolved pursuant to the Provider Dispute Resolution Procedure specified above shall be resolved by binding arbitration at the request of either Party, in accordance with the Commercial Rules of the American Arbitration Association. Such arbitration shall occur in Sacramento, California, unless the Parties mutually agree to have such proceeding in some other locale. The arbitrator

shall apply California substantive law and federal substantive law where state law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with the provisions of California law, and the arbitrator selected shall have the power to enforce the rights, remedies, duties, liabilities and obligations of discovery by the imposition of the same terms, conditions and penalties as can be imposed in like circumstances in a civil action by a court of competent jurisdiction of the State of California. California Civil Code Section 1283.05, the provisions of California law concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement.

The arbitrator shall have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages shall not be awarded. The arbitrator shall prepare a decision in writing.

Notwithstanding the above, in the event either Medical Group or PacifiCare wishes to obtain injunctive relief or a temporary restraining order, such Party may initiate an action for such relief in a court of general jurisdiction in the State of California. The decision of the court with respect to the requested injunctive relief or temporary restraining order shall be subject to appeal only as allowed under California law. However, the courts shall not have the authority to review or grant any request or demand for damages.

Exhibit H

Termination List

H.1 Sutter Medical Center, Sacramento—Secure Horizons

H.2 Memorial Hospital Association – Secure Horizons

H.3 Alta Bates Medical Center—Secure Horizons

H.4 Sutter Solano Medical Center—Commercial and Secure Horizons

H.5 Sutter Delta Medical Center—Commercial and Secure Horizons

H.6 Eden Medical Center—Secure Horizons

H.7 Sutter Medical Center of Santa Rosa—Secure Horizons (FHP)

H.8 Marin General Hospital – Secure Horizons (FHP)

H.9 Sutter Maternity and Surgery Center—Sutter Santa Cruz Medical Center—Commercial and Secure Horizons (PacifiCare)

PACIFICARE
PMG COMMERCIAL
RISK SERVICES AGREEMENT

This PMG COMMERCIAL RISK SERVICES AGREEMENT (the "Agreement") is made and entered into this first day of December 1995 by and between PACIFICARE OF CALIFORNIA ("PacifiCare"), a California corporation, and SUTTER INDEPENDENT PHYSICIANS ("PMG"), a California Corporation, with reference to the following facts:

A. PacifiCare operates a prepaid health care service plan which arranges for certain Health Care Services to be provided to persons who are enrolled in the PacifiCare Health Plan in a manner consistent with the laws of the United States and the State of California.

B. PacifiCare desires to provide a quality direct service prepaid health delivery system which maximizes the utilization of innovative methods to promote the efficient, economical delivery of health care, and to develop and implement programs of health education and health maintenance for its Subscribers.

C. PMG has as its primary objective the delivery of Medical Services through agreements and active participation with individual physicians, medical groups and/or clients, their physicians and other related health professionals and technicians, all of which are appropriately licensed in the State of California.

D. PMG desires to participate in PacifiCare's prepaid health service delivery system by arranging or providing Health Care Services in coordination with PacifiCare, its Subscribers and participating hospitals on a prepaid basis.

E. PacifiCare and PMG deem it in their best interests to enter into a renewable agreement whereby PMG agrees to provide or arrange Health Care Services to persons who are enrolled at Subscribers in the PacifiCare Health Plan.

NOW THEREFORE, it is agreed as follows:

1. *DEFINITIONS*

Whenever used in this Agreement, the following terms shall have the definitions contained in this Section 1:

AGREEMENT—is this PacifiCare PMG Commercial Risk Services Agreement, dated as herein above stated, including all attachments, addenda and amendments hereto.

CAPITATION PAYMENTS—are payments made to PMG by PacifiCare on a prepaid basis, as set forth in Attachment C, incorporated in full herein by reference, for the capitated Medical Services to be provided under this Agreement.

CATASTROPHIC CASE—is any medical condition, including complications arising from such medical condition, where the total cost of Health Care Services to treat such condition is expected to exceed fifty thousand dollars ($50,000) per condition, regardless of payment source.

CONFORMANCE REQUEST—is a written request made by PacifiCare to PMG to correct the performance of an PMG physician or Contracting Provider to conform to the provisions of this Agreement.

CONTRACTING PROVIDERS—may be specialist physicians, Vendors, or ancillary providers that are not Member Physicians and who are contracted by PMG to provide non-primary care services to Subscribers on a referral basis

COPAYMENTS—are charges pursuant to the PacifiCare Health Plan which may be charged to the Subscriber by the PMG at the time of provision of Health Care Services and which are in addition to the Capitation Payments paid to PMG by PacifiCare.

COST OF CARE—is the value of Medical Services as defined in this Agreement and as calculated pursuant to the formula set forth in Attachment A2 incorporated in full herein by reference

ELIGIBILITY LIST—is a list of Subscribers designated by Medical Group to whom PMG shall provide or arrange Health Care Services.

EMERGENCY SERVICES—are those Health Care Services furnished to a Subscriber for the treatment of acute injury or illness requiring immediate medical attention and which threaten life or limb, or which involve uncontrollable bleeding, or loss of consciousness, or which cannot be delayed without possible serious effects on the health of the Subscriber.

HEALTH CARE SERVICES—are all PMG authorized services to which Subscribers are entitled under the PacifiCare Health Plan, including Medical Services, Hospital Services and Emergency Services.

HOSPITAL—is an acute care facility (or facilities) located in the PMG Service Area, licensed as an acute care hospital under the laws of the State of California and which has a written agreement with PacifiCare to provide Hospital Services to Subscribers. For purposes of this Agreement, Hospital shall be Sutter Health Central (d.b.a. Sutter Auburn Faith Hospital, Sutter Center for Psychiatry, Sutter Davis Hospital, Sutter General Hospital, Sutter Memorial Hospital and Sutter Roseville Medical Center.

HOSPITAL DAY—is any twenty-four (24) hour period commencing at 12:00 a.m., or 12:00 p.m., whichever is used by a Hospital to determine a Hospital Day, during which a Subscriber receives Hospital Services at a Hospital.

HOSPITAL SERVICES—are the Health Care Services described in Attachments F, incorporated in full herein by

reference, which Hospitals and other PacifiCare contracting providers shall provide to Subscribers and when PMG shall arrange or coordinate for Subscribers pursuant to the PacifiCare Health Plan.

PMG—is the independent practice association identified in the first paragraph of this Agreement and its Member Physicians, all of whom are licensed to practice medicine or osteopathy in the State of California at the PMG Facilities.

PMG FACILITIES—are those facilities whose locations are provided to PacifiCare from time to time, where Medical Services shall be available to Subscriber pursuant to this Agreement.

PMG SERVICE AREA—is the geographical area within a thirty (30) mile radius of each Hospital Facility as specified in Attachment H. Such radius commences with the address of each designated Hospital Facility and extends for thirty (30) miles over the shortest route using public streets and highways.

MEDICAL SERVICES—are the PMG authorized Health Care Services to which Subscribers are entitled under the PacifiCare Health Plan, as described in Attachment F, incorporated in full herein by reference.

MEDICALLY NECESSARY SERVICES—are those Health Care Services required by Subscriber which are, in PMG's professional opinion:

(a) Appropriate for the symptoms and diagnosis or treatment of a condition, illness, or injury; and

(b) Provided for the diagnosis, or the direct care and treatment of the condition, illness or injury; and

(c) In accordance with the standards of good medical practice in the PMG Service Area; and

(d) Not primarily for the convenience of the Subscriber, or the Subscriber's physician and surgeon or other provider; and

(e) The most appropriate health service to be provided to the Subscriber; and

(f) Consistent with the medical policies, the Utilization Review Committee, Quality Assurance Committee and PacifiCare Health Plan as identified in the Agreement by attachment and mutually agreed upon by PacifiCare and PMG upon execution of the Agreement.

MEMBER PHYSICIANS—are primary care and/or specialist physicians, surgeons and osteopaths licensed to practice medicine in the State of California who have become members of PMG pursuant to the membership requirements set forth in the Bylaws of PMG.

OUTSIDE PROVIDERS—are licensed physicians, surgeons, osteopaths, paramedics, hospitals and other licensed health care facilities which provide PMG authorized Health Care Services to Subscribers, but which do not have written agreements with PMG or PacifiCare and which are not Contracting Provider physicians.

PACIFICARE HEALTH PLANS—is any one of the various prepaid health service plans operated by PacifiCare as described in the PacifiCare Medical and Hospital Group Subscriber Agreement, the PacifiCare Medical And Hospital Individual Conversion Member Agreement and PacifiCare Medical and Hospital Individual Subscriber Agreement, and attachments, addenda, supplements and periodic amendment thereto, copies of which are attached hereto and Attachment B, incorporated in full herein by reference. For purposes of this Agreement, the PacifiCare Health Plan shall not include PacifiCare's Secure Horizons Plan.

PACIFICARE INDIVIDUAL PLAN—is the health plan sold to individuals.

PARTICIPATING MEDICAL GROUP—includes PMG and its Members Physicians and is any duly licensed doctor of medicine or osteopathy that has directly, or as a member of a group or association of licensed doctors of medicine or osteopathy, entered into a written agreement with PacifiCare to provide Health Care Services in conjunction with the PacifiCare Health Plan.

QUALITY ASSURANCE COMMITTEES—are committees separately established by Medical Group and PacifiCare which shall establish, maintain and perform quality assurance review of Medical Services provided to Subscribers as reasonably required by PacifiCare, the California Department of Corporations, the Office of Qualification and Compliance, the United States Department of Health and Human Services or any other governmental agencies with regulatory or enforcement jurisdiction over PacifiCare or this Agreement

REFERRALS—are recommended directions of Subscribers from PMG to physicians, including Contracting Providers, Outside Providers who are physicians and/or consultant physicians, or providers of ancillary services such as lab, x-ray and physical therapy, EKG, EEG, health education, medical social service, home health care, mental health and acute alcohol and drug abuse services, for the purpose of obtaining Health Care Services.

SUBSCRIBER—is an individual who is enrolled in a PacifiCare Health Plan, who meets all the eligibility requirements for membership in such plan, who has designated PMG as his or her primary care coordinator and for whom all applicable Subscriber Premiums have been paid and received by PacifiCare. For the purpose of this Agreement, Subscriber shall include all eligible dependents of the individual named by PacifiCare for coverage under a PacifiCare Health Plan

SURCHARGES—are additional fees which are not disclosed to Subscriber for Health Care Services and which are not allowable Copayments.

UTILIZATION REVIEW COMMITTEE—is a Medical Group committee of at least three (3) Member Physicians which is established and maintained, in accordance with the provisions of Section 3.13 herein, to develop a utilization control program outlining procedures for the efficient use of resources, consistent with state and federal law, for the rendition of Health Care Services. The Utilization Review Committee shall review elective Referrals and hospital admissions on a concurrent and prospective basis and Emergency Services and hospital admissions on a retrospective basis.

PACIFICARE POINT OF SERVICE—is a health plan consisting of the PacifiCare Health Plan, plus the Out-of-Network Indemnity Plan.

OUT-OF-NETWORK INDEMNITY PLAN—is a supplemental health plan offered as part of the PacifiCare Point of Service by an insurance company or a self-insured employer which provides limited coverage for Out-of-Network Services.

PACIFICARE IN-NETWORK PLAN—is the PacifiCare Health Plan that is sold in conjunction with the Out-of-Network Indemnity Plan as part of PacifiCare Point of Service.

CONVENTIONAL PLAN—is the PacifiCare Health Plan which is *not* sold as part of the PacifiCare Point of Service.

IN-NETWORK SERVICES—are Health Care Services which are provided or arranged by PMG to PacifiCare Point of Service Subscribers pursuant to the PacifiCare Health Plan.

OUT-OF-NETWORK MEDICAL SERVICES—are the Health Care Services designated in Attachment F as Medical Services obtained by PacifiCare Point of Service Subscribers which are not authorized by PMG in accordance with PacifiCare's prepaid Health Plan.

OUT-OF-NETWORK HOSPITAL SERVICES—are the Health Care Services designated in Attachment F as Hospital Services obtained by PacifiCare Point of Service Subscribers which are not arranged or coordinated by PMG in accordance with PacifiCare's prepaid Health Plan, and which do not qualify as Emergency Services.

OUT-OF-NETWORK SERVICES—are Out-of-Network Medical Services and Out-of-Network Hospital Services. Out-of-Network Services are covered in part under the Out-of-Network Indemnity Plan, but are not covered under the PacifiCare Health Plan. PMG shall have no financial responsibility for Out-of-Network Services

NET PREMIUM—is the amount of gross premiums billed by PacifiCare each month for coverage of Subscribers designating PMG as their Participating Medical Group, excluding amounts billed by PacifiCare to cover broker commissions and optional supplemental benefits.

PHARMACY PREMIUM—is the gross premiums billed by PacifiCare each month for coverage of Subscribers for the outpatient prescription drug benefit.

VENDOR—shall mean any provider of additional Health Care Services including, but not limited to, laboratory work, radiology, medical supplies, home health services and outpatient services.

2. *RELATIONSHIP OF PARTIES*

2.01 *PMG PARTICIPATION*—The execution of this Agreement shall qualify PMG to participate in the provision or arrangement of Health Care Services to Subscribers

pursuant to the terms of the PacifiCare Health Plan, as amended from time to time. Subject to Section 12.13, PacifiCare shall notify PMG in writing of any proposed material amendments to the PacifiCare Health Plan, which amendments shall become effective upon sixty (60) days written notice by PacifiCare to PMG, provided PMG has not objected to the amendments in writing to PacifiCare within the sixty (60) day period. PMG approval of such amendments shall not be unreasonably withheld. If PMG provides PacifiCare with reasonable written objection within the sixty (60) day period, such amendments shall have no force or effect on PMG.

2.02 *RESPONSIBILITY FOR OWN ACTS*—Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement. In the event that a claim is made against both parties, it is the intent of both parties to cooperate in the defense of said claim and to cause their insurers to do likewise. However both parties shall have the right to take any and all actions they believe necessary to protect their interest.

2.03 *INDEPENDENT CONTRACTOR*—The relationship between PacifiCare and PMG is an independent contractor relationship. Neither PMG nor its employees or agents are employees or agents of PacifiCare and neither PacifiCare nor any employee or agent of PacifiCare is a member, partner, employee or agent of PMG. All medical decisions are rendered solely by PMG and not by PacifiCare. PMG is solely responsible for all Health Care Services provided or arranged by PMG for Subscribers. None of the provisions of this Agreement shall be construed to create a relationship of

agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

3. *DUTIES OF PMG*

3.01 *PMG RESPONSIBILITIES*—PMG agrees to arrange for or provide Health Care Services twenty-four (24) hours a day in coordination with PacifiCare for each Subscriber who has designated PMG as his or her Participating Medical Group. PMG shall be financially responsible for all Medical Services which are specified in Attachment F, incorporated in full herein by reference, and which are provided to Subscribers for whom PMG should receive a monthly Capitation Payment from PacifiCare based upon the PacifiCare provided Eligibility List. PMG shall be responsible for determining whether Subscribers are eligible for Health Care Services on the basis of the most current Eligibility List supplied to PMG by PacifiCare.

3.02 *STANDARDS*—All Medical Services arranged for or provided by PMG and its Member Physicians shall be provided by professional personnel and at physical facilities according to generally accepted standards of medical practice and management in the community. PMG further agrees to provide or arrange for Referrals to physicians and facilities as are necessary, appropriate, and in accordance with generally accepted standards of medical practice in the community in compliance with the standards developed by PacifiCare's Quality Assurance Committee. If PMG contracts with Contracting Provider physicians to provide Medical Services under this Agreement. PMG shall require such physicians to provide PMG with the credentialing information set forth herein. PMG shall obtain and maintain information concerning each Member Physician's and Contracting Provider physician's education, training, references, malpractice liability insurance, hospital staff status, hospital clinical

privileges, and hospital staff reappointment dates. Such information shall be kept in a form prescribed by or acceptable to PacifiCare. Upon written request, at least 72 hours in advance, the credentialing information shall be made available to PacifiCare for review or copying.

PMG acknowledges and agrees that it shall report Member Physicians or Contracting Provider physicians as required by the California Business and Professions Code Section 805 ("Section 805"). PMG further agrees to maintain and demonstrate to PacifiCare upon request compliance with the following:

3.02.01 PMG shall ensure that its Member Physicians and Contracting Provider physicians are licensed by the State of California and have current Drug Enforcement Agency ("DEA") registration. PMG shall immediately notify PacifiCare in writing of any of the following actions taken by or against a Member Physician or Contracting Provider physicians, once PMG has knowledge that such an action has taken place: (i) the surrendering, revocation, or suspension of a license; (ii) the surrendering, revocations, or suspension of current DEA registration; (iii) any filing pursuant to Section 805; (iv) any filing pursuant to the National Practitioner Data Bank; (v) the filing of any malpractice settled claim of more than ten thousand dollars ($10,000); and (vi) a change in hospital staff status or hospital clinical privileges, including any restrictions or limitations.

PMG will use its best efforts to obtain and maintain the information set forth in Paragraph 3.02 and to immediately notify PacifiCare as set forth in this Paragraph 3.02.01.

3.02.02 In the event that it is determined by PacifiCare that PMG does not obtain and maintain the information set forth in paragraph 3.02, PMG agrees to assist

PacifiCare in obtaining credentialing information concerning each Member Physician's and Contracting Provider physician's education, training, references, malpractice liability insurance, hospital staff status, hospital clinical privileges, and hospital staff reappointment dates. PMG shall make best efforts to obtain from each Member Physician and Contracting Provider physician a signed waiver, acceptable to PacifiCare, allowing PacifiCare access to such credentialing information at any acute care hospital or health care facility. If PMG is unable to obtain a signed waiver from a Member Physician or Contracting Provider physician, PMG shall obtain the credentialing information directly from the acute care hospital or health care facility and make such information available to PacifiCare upon request for review and copying.

3.02.03 PMG agrees to provide access to continuing education programs for its Member Physicians in accordance with the standards established by the California Medical Association for continuing education. The content and delivery of such continuing education programs shall be at the discretion and judgment of PMG, in order to maintain high standards for the delivery of Medical Services pursuant to this Agreement. PMG further agrees to gather, correlate, and distribute to its Member Physicians, information regarding professional medical activities and developments which PMG believes may be of assistance in providing Medical Services pursuant to this Agreement.

3.03 *INSURANCE*

3.04 *REFERRALS*—PMG shall refer Subscribers in need of specialty care services only with the approval of the PMG Utilization Review Committee. However, in the event that Emergency Services are required, PMG shall comply with Section 3.05 below.

3.05 *HOSPITAL ADMISSIONS*—whenever PMG determines that a Subscriber on PMG's Eligibility List requires Hospital Services that are not Emergency Services, PMG shall arrange for such Hospital admissions and outpatient surgeries through the PMG's Utilization Review Committee and its developed utilization review program. PMG and its Member Physicians shall comply with this Section 3.05 for all admissions except in the event that Emergency Services are required. If PMG or a Member Physician has knowledge that a Subscriber has been admitted to a hospital due to an out-of-area Emergency, PMG shall notify PacifiCare of such admission within the time frames as required in the PacifiCare Provider Policies and Procedures Manual, attached hereto as Attachment D and incorporated in full herein by reference. All other admissions in-area except for Emergency Services shall be made to Hospital capitated with PacifiCare for the same Subscribers, unless approval by Hospital is obtained. In the event PMG refers a Subscriber to a hospital outside the Sutter Health system, without authorization from Hospital, PMG shall be financially liable for any professional or facility charges incurred as a result of the referral.

3.06 *ELIGIBILITY LIST*—PMG shall accept as patients those Subscribers who are on PMG's Eligibility List provided by PacifiCare to PMG. Member Physicians and PMG shall be entitled to rely on the most current provided list until a new list has been provided to PMG.

3.07 *COLLECTION OF CHARGES FROM SUBSCRIBERS*—PMG shall collect applicable Copayments from Subscribers upon the rendition of Medical Services to Subscribers pursuant to the PacifiCare Health Plan. With the exception of Copayments and charges for non-covered services delivered on a fee-for-service basis to Subscribers, PMG shall in no event, including, without limitation, nonpayment by PacifiCare, insolvency of PacifiCare, or breach

of the Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive any form of payment, from any Subscriber for Medical Services provided pursuant to this Agreement and for which Subscriber is entitled under the PacifiCare Health Plan in effect for such Subscriber.

PMG shall not maintain any action at law or equity against a Subscriber to collect sums owed by PacifiCare to PMG. Upon notice of any such charge, PacifiCare may terminate this Agreement consistent with the provisions contained in Section 7.01.02 and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges, including, without limitation, requiring PMG and Contracting Providers to return all sums collected as Surcharges from Subscribers or their representatives. Nothing in this Agreement, however, shall be construed to prevent PMG from providing non-covered Medical Services on a usual and customary fee-for-services basis to Subscribers.

PMG's obligations regarding the collection of charges from Subscribers shall survive the termination of this Agreement with respect to Health Care Services provided during the term of the Agreement without regard to cause of termination of this Agreement. Except as provided elsewhere herein, these obligations shall not apply to services provided after the Agreement has been terminated and the phase-out period has expired pursuant to Section 3.09, if applicable.

3.07.01 *Collection of Charges for Out-of-Network Services.* Notwithstanding anything to the contrary in Section 3.07 or elsewhere in the Agreement, if a PMG Member Physician or Contracting Provider provides Out-of-Network Services to a PacifiCare Point of Service Subscriber, PMG shall bill the Out-of-Network Indemnity Plan carrier for such services and agrees to accept full reimbursement at the Cost of Care rates described in Attachment A2 of this Agreement.

3.08 *COLLECTION OF CHARGES FROM THIRD PARTIES*—PMG and Member Physicians accept payment from PacifiCare (plus applicable Copayments) for Medical Services as provided herein as full payment for such Medical Services; provided however, in the event the Subscriber is entitled to payment from another third party or for payment for a Workers' Compensation claim, or from other primary insurance coverage maintained by Subscriber, PMG and Member Physicians shall make no demand upon PacifiCare for reimbursement under the Individual Subscriber Stop Loss Program as specified in Attachment A1 hereto until all primary sources of payment have been pursued and it is determined that full payment cannot be obtained within ten (10) months from the date of the provision of Medical Services.

For purposes of accomplishing the intent of this subsection, PacifiCare hereby assigns to PMG for collection, any claims or demands against third parties for amounts due for Medical Services provided by PMG pursuant to this Agreement, subject to the following conditions:

3.08.01 PMG shall not commence any legal or equitable action against a third party without prior notification to PacifiCare. It is agreed that collection or demand letters consistent with the PacifiCare Provider Policies and Procedures Manual shall not constitute the commencement of legal or equitable action. Under no circumstances, shall PMG commence any legal action against a Subscriber for payment.

3.08.02 PMG shall hold PacifiCare harmless for all actions by PMG pursuant to this Section 3.08.

In the event PMG receives payment from a third party after receipt of payment from PacifiCare, PMG shall reimburse PacifiCare to the extent that the combined amounts received from all payers exceeds one hundred percent (100%) of PMG's usual and customary fee-for-service charges.

3.09 *DUTIES OF PMG UPON TERMINATION DURING PHASE-OUT PERIOD*—Should this Agreement be terminated by PMG pursuant to Sections 7.0.01(a), 7.01.01(b), 7.01.01(c) or 7.01.01(d), PMG shall be released of its obligation to continue to provide or arrange for Health Care Services to Subscribers during the phase-out period as stated in this Section 3.09. If this Agreement is terminated for any other reason by either party or if this Agreement terminates at the end of the Initial Term or any renewal term, PMG shall not be released of its obligation to continue to provide or arrange for Health Care Services to Subscribers during the phase-out period, which phase-out period shall end on the earlier of:

3.09.01 Twelve (12) months from the notification date of termination of this Agreement, or

3.09.02 The date PacifiCare has secured the transfer of Subscribers to another medical group, individual practice association, or physician for further treatment, and has notified PMG of such transfer in writing.

Compensation during the phase-out period shall be at the Cost of Care rates set forth in Attachment A2 hereto and incorporated in full herein by reference.

3.10 *CONTINUING CARE RESPONSIBILITIES*—In the event of termination of this Agreement and the expiration of PMG's duty to provide or arrange Health Care Services during the phase-out period pursuant to Section 3.09, if applicable, PMG and Member Physicians shall continue to provide or arrange for Health Care Services to Subscribers until the effective date of transfer of such Subscribers to another Participating Medical Provider for further treatment and written notice of such transfer has been provided by PacifiCare to PMG. If a Subscriber's care cannot be transferred for the reason of Subscriber hospitalization, continuity of care, or other legally required medical treatment

reasons, PMG shall continue to provide or arrange for treatment for the Subscriber until PacifiCare has made provision for the transfer of such Subscriber to another Participating Medical Provider for further treatment and has notified PMG of such transfer in writing. The payment provisions for any continued treatment after expiration of the phase-out period shall be eighty percent (80%) of the usual and customary fees of the treating physician.

Notwithstanding the above or any other provision to the contrary, PMG agrees that in the event PacifiCare ceases operations for any reason, including insolvency, PMG shall provide or arrange Health Care Services and shall not bill, charge, collect or receive any form of payment from any Subscriber or have any recourse against a Subscriber for Health Care Services provided after PacifiCare ceases operations. This continuation of Health Care Services obligation shall be for the period for which premium has been paid, but shall not exceed a period of thirty (30) days, except for those Subscribers who are hospitalized on an inpatient basis as provided below.

In the event PacifiCare ceases operations or PMG terminates this Agreement on the basis of PacifiCare's failure to make timely Capitation Payments, PMG shall continue to arrange for Health Care Services to those Subscribers who are hospitalized on an inpatient basis at the time PacifiCare ceases operations or PMG terminates this Agreement until such Subscribers are discharged from the hospital. PMG may file a claim with PacifiCare for such services as previously specified in this Section 3.10.

PMG agrees that the provisions of this Section and PMG's and Member Physicians' obligations herein shall survive the termination of this Agreement without regard to the cause of termination of the Agreement, and shall be construed to be for the benefit of the Subscribers.

3.11 *STAFF PRIVILEGES*—PMG agrees to have its Member Physicians seek and obtain (and provide evidence of) staff privileges or other appropriate access to Hospitals where Health Care Services shall be provided to Subscriber by PMG's Member Physicians.

3.12 *ADMINISTRATIVE GUIDELINES*—PMG agrees to perform its duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by PacifiCare, in its Provider Policies and Procedures Manual, attached hereto as Attachment D and incorporated in full herein by reference. Subject to Section 12.13 herein, PacifiCare shall notify PMG in writing of any proposed material amendments to the administrative guidelines, which amendments shall become effective upon sixty (60) days written notice by PacifiCare to PMG provided PMG has not objected to the amendments in writing to PacifiCare within the sixty (60) day period. PMG approval of such amendments shall not be unreasonably withheld. If PMG provides PacifiCare with reasonable written objection within the sixty (60) day period, such amendments shall have no force or effect on PMG.

3.13 *UTILIZATION REVIEW*—PMG agrees to participate with PacifiCare in an ongoing utilization review program to promote efficient use of resources. The PMG's Utilization Review Committee shall meet as frequently as necessary but at least monthly. The Utilization Review Committee shall keep minutes of the committee meetings, a copy of which shall be made available to PacifiCare upon ten (10) days written notice by PacifiCare to PMG. PMG and PacifiCare shall jointly implement a utilization review system whereby PMG shall notify PacifiCare of any hospital admissions. A member of the PacifiCare medical services staff may participate in PMG's Utilization Review Committee meetings upon ten (10) days written notice. Participation in and/or request of information from Utilization Review Committee meetings shall be limited to PacifiCare members.

3.14 *QUALITY OF HEALTH CARE SERVICES*—PMG agrees to assure quality of Health Care Services by:

3.14.01 Assigning PacifiCare Subscribers only to Member Physicians or Outside Providers meeting quality health care standards.

3.14.02 Inspecting the premises and facilities of its Member Physicians on a regular basis and allowing PacifiCare to participate in such inspections upon ten (10) days written notice.

3.14.03 Utilizing the PacifiCare Quality Assurance Committee's guidelines for physician credentialing.

3.15 *QUALITY ASSURANCE AND REMEDIAL PROCEDURES*—PMG shall cooperate with PacifiCare in the operation of PacifiCare's quality assurance program and PMG shall perform quality assurance review of Health Care Services as brought before PMG internally or from PacifiCare's Quality Assurance Committee. PMG shall establish and maintain a Quality Assurance Committee which shall meet at least quarterly. A member of the PacifiCare medical services staff, in accordance with PMG's policies and procedures, may participate in PMG's Quality Assurance Committee meetings upon ten (10) days written notice. The PMG Quality Assurance Committee shall keep minutes of the committee meetings, a copy of which shall be made available to PacifiCare upon ten (10) days written notice by PacifiCare to PMG. The task of the Quality Assurance Committee may be assumed by the Utilization Review committee described in Section 3.13; however, in such event, the Utilization Review and Quality Assurance Committees must hold separately convened meetings and the minutes of each meeting must be separately maintained.

PMG shall, at the written request of PacifiCare, make available one (1) Member Physician from PMG to attend the PacifiCare Quality Assurance Committee meetings. The

intent of this Section is to have at least one Member Physician from PMG serve for six (6) months on the PacifiCare Quality Assurance Committee during a three (3) year period. PacifiCare shall use best efforts to make available a reasonable stipend for such Member Physician. PMG shall develop written procedures for remedial action whenever it is determined by PacifiCare's Quality Assurance Committee, inappropriate or substandard Health Care Services have been furnished or Health Care Services that should have been furnished have not been furnished. Upon PMG's request, PacifiCare shall assist PMG in the formulation of such remedial procedures.

3.16 *RECIPROCITY AGREEMENTS*—PMG agrees to make best efforts to develop agreements among PacifiCare's Participating Medical Groups to assure reciprocity of health care among the Participating Medical Groups for PacifiCare Subscribers. PMG shall accept non-emerg ncy or specialty Referrals, limited to those services provided by Member Physicians, from such other Participating Medical Groups and such other Participating Medical Groups shall be required to accept non-emergency or specialty Referrals from PMG. Payment for the foregoing Referrals shall be made at the Cost of Care Rates described in Attachment A2.

3.17 *INDIVIDUAL STOP-LOSS PROGRAM*—PMG agrees to participate in and assume the rights and responsibilities of the PacifiCare Stop-Loss Program as defined in Attachment A1, attached hereto and incorporated in full herein by reference.

3.18 *OTHER CONTRACTUAL COMMITMENTS*—PMG represents and assures PacifiCare that contractual commitments with other HMOs, competitive medical plans and health related entities do not restrict or impair PMG from performing its duties under this Agreement.

3.19 *DISSEMINATION OF INFORMATION*—PMG agrees that PacifiCare may use PMG's name, address, telephone number, and a listing of PMG's Member Physicians, and designated Contracting Providers, in any informational material routinely distributed to Subscribers and for other purposes related to the administration of the PacifiCare Health Plan as an indication of PMG's willingness to provide Health Care Services to Subscribers.

Prior to listing or otherwise referencing PacifiCare in any promotional or advertising brochures, media announcements or other advertising or marketing material, PMG shall first obtain the prior subjective consent of PacifiCare. Additionally, prior to the publication of a listing of PMG's Member Physicians and Contracting Providers in any marketing material, PacifiCare agrees to provide PMG with the opportunity to review and modify such listing. PMG agrees to conduct its review and return the listing to PacifiCare within ten (10) working days of receipt of initial listing.

PacifiCare shall agree to educate employers about benefit packages and changes associated with those benefit packages.

3.20 *WRITTEN AGREEMENTS*—PMG shall use best efforts to secure written agreements, consistent with the terms of this Agreement and in compliance with all applicable state and federal law, with all Contracting Providers regularly utilized as a part of PMG's referral system.

3.21 *MEDICAL CARE CRITERIA*—PMG shall utilize the criteria for medical care that is established or approved by PacifiCare's Quality Assurance Committee as a standard reference in determining appropriate lengths of stay for hospitalized Subscribers or appropriate utilization patterns for referral to specialty services.

3.22 *NON-DISCRIMINATION*—PMG represents and assures that Health Care Services are rendered to Subscribers in the same manner as such services are provided to PMG's other patients, except as required pursuant to this Agreement. Subscribers shall not be subject to any discrimination whatsoever by PMG in regards to access to Health Care Services.

3.23 *ACCOUNTS PAYABLE SYSTEM*—PMG agrees to operate its accounts payable system in a manner which assures that providers of authorized Medical Services who are Member Physicians and non-Member Physicians receive payment for Medical Services rendered to Subscribers within forty-five (45) working days of PMG's receipt of an uncontested claim from such Member Physicians and non-Member Physicians. In the event PMG fails to meet the payment timelines discussed in this Section 3.23, in addition to exercising any other remedies it may have under this Agreement, PacifiCare may take actions to assist PMG in operating its accounts payable system including, but not limited to, assuming the obligation of paying PMG's Member Physicians and Non-Member Physicians upon forty-five (45) days written notice and charging PMG an administrative fee for performing such services. Such action shall only be carried out as a result of PMG's failure to cure accounts payable system deficiencies.

3.24 *CATASTROPHIC CASE MANAGEMENT*—PMG agrees that PacifiCare's Medical Director may be involved in the management and coordination of Catastrophic Cases. PMG will fully assist PacifiCare in providing information that may be required in determining the need for a transfer of a Subscriber into PacifiCare's regional centers for the care of Catastrophic Cases including, but not limited to, prompt notification of known or suspected Catastrophic Cases. Detailed procedures for Catastrophic Case management will be mutually agreed upon by the parties based upon PMG's and PacifiCare's determination of the Subscriber's

transferability. Except in unusual circumstances, regional centers for care of Catastrophic Cases shall be sought within the PMG Service Area and surrounding area.

3.25 *CAPACITY REPORTING*—PMG will provide to PacifiCare, at the earliest possible time, notice of any significant changes in the capacity of PMG to provide or arrange for the Health Care Services contemplated by this Agreement (e.g. addition or deletion of Member Physicians), including a ninety (90) day written notice in the event PMG is unable to properly service additional Subscribers. PMG shall still be obligated to provide or arrange for Health Care Services to Subscribers who are with employer groups whom PacifiCare had agreed to enroll prior to ninety (90) days from the effective date of the written notice. PacifiCare shall provide PMG, upon PMG's request, current marketing information within a reasonable period for purposes of determining PMG capacity.

3.26 *REPRESENTATION OF PMG MEMBER PHYSICIANS*—PMG agrees to represent its Member Physicians in matters pertaining to the provision of Health Care Services under this Agreement, and that it has obtained written consent to such representation from its Member Physicians.

3.27 *PERFORMANCE OF MEMBER PHYSICIANS*—PMG agrees: (i) to develop methods for discussion of performance with its Member Physicians, (ii) to assure correction of performance of its Member Physicians consistent with the provisions of this Agreement and state and federal law applicable to the PacifiCare Health Plan, and (iii) to resolve Conformance Requests.

3.28 *WITHDRAWAL OF A PMG FACILITY*—In the event PMG seeks to withdraw one or more of its current PMG Facilities from providing or arranging for Health Care Services to Subscribers under this Agreement, PMG will use its best efforts to notify PacifiCare of such withdrawal in

writing at least sixty (60) days prior to the effective withdrawal date: after the effective date of withdrawal, PMG shall still be responsible to provide or arrange for Health Care Services to the affected Subscribers at the other PMG Facilities.

3.29 *PACIFICARE POINT OF SERVICE CONTROL PROGRAM*—PMG agrees to participate in and have the rights and responsibilities applicable to the PacifiCare Point of Service Control Program as set forth in Attachment A4, attached hereto and incorporated herein.

3.30 *WITHDRAWAL OF A MEMBER PHYSICIAN*—In the event PMG seeks to withdraw one or more of the Member Physicians from providing or arranging Health Care Services to Subscribers under this Agreement, PMG will use its best efforts to notify PacifiCare of such withdrawal in writing at least sixty (60) days prior to the effective withdrawal date. After the effective date of withdrawal, PMG shall still be responsible to provide or arrange for Medical Services to such Subscribers.

4. *DUTIES OF PACIFICARE*

4.01 *ADMINISTRATION*—PacifiCare agrees to perform all necessary administrative, accounting, enrollment and other functions consistent with the administration of the PacifiCare Health Plan and this Agreement.

4.02 *BENEFIT INFORMATION*—PacifiCare agrees to apprise all Subscribers concerning the type, scope and duration of benefits and services to which such Subscriber is entitled under the PacifiCare Health Plan.

4.03 *ASSIST PMG*—PacifiCare agrees to assist and cooperate with PMG in the development and initial implementation of procedures necessary to carry out the intent of this Agreement.

4.04 *ADMINISTRATION OF PAYMENTS*—PacifiCare agrees to transmit Capitation Payments and other payments to PMG in accordance with the terms and procedures set forth in this Agreement.

4.05 *STATISTICAL INFORMATION AND PROVISION OF DATA*—PacifiCare agrees to provide PMG with management information and data reasonably necessary to carry out the terms and conditions of this Agreement and for the operation of the PacifiCare Health Plan including monthly Eligibility Lists and monthly capitation worksheets. Furthermore, PacifiCare shall provide, upon request, quarterly reports reflecting the utilization of Health Care Services rendered by PMG. In the event that PacifiCare does not provide the eligibility list to PMG by the fifteenth (15th) day of the month, due to administrative inefficiencies, PacifiCare shall pay PMG $250.00 per day until said eligibility list is delivered to PMG or PMG's designee. In the event that the eligibility list cannot be delivered on or before the fifteenth (15th) day of any month due to reasons mutually agreed to be beyond PacifiCare's control, PacifiCare shall notify PMG or PMG's designee and shall not pay $250.00 per day until the eligibility list is delivered.

4.06 *SERVICES RENDERED TO INELIGIBLE SUBSCRIBERS*—PacifiCare agrees to reimburse PMG for those Medical Services set forth in Attachment F which were provided to an ineligible Subscriber if the Subscriber was listed as eligible on the most current Eligibility List provided to PMG by PacifiCare. If PacifiCare is in receipt of a billing to such ineligible Subscriber from PMG and proof of having sent the Subscriber or the Subscriber's legal guardian two (2) bills no less than thirty (30) days apart, PacifiCare will reimburse PMG at the Cost of Care as defined in Attachment A2, rates then in effect for those Medical Services rendered but no greater than one hundred percent (100%) of the still uncollected balance. If subsequent to payment by PacifiCare,

PMG receives any payment from another source for the services, then PMG shall reimburse PacifiCare up to the amount previously received from PacifiCare. If a Subscriber becomes ineligible for benefits under the PacifiCare Health Plan after PMG or Member Physicians have begun treatment of the Subscriber (provided the Subscriber is not hospitalized at the time of becoming ineligible), PMG shall be entitled to make all subsequent charges for its services directly to the Subscriber. If the Subscriber is hospitalized at the time of becoming ineligible, PMG shall be entitled to make charges directly to the Subscriber only for services provided after the Subscriber becomes ineligible.

4.07 *DISSEMINATION OF INFORMATION*—Except as provided above in Section 3.19, prior to listing or otherwise referencing PMG in any promotional or advertising brochures, media announcements or other advertising marketing material, PacifiCare shall first obtain the prior consent of PMG, such consent not to be unreasonably withheld.

4.08 *RETROACTIVE MEMBER CANCELLATIONS AND ADDITIONS*

4.08.01 *Cancellations*. If a Subscriber is retroactively disenrolled, PacifiCare will deduct the overpayment for the appropriate number of months, as determined by PacifiCare, up to a maximum of three (3) months, from the next month's PMG Capitation Payment. If PMG can demonstrate that Health Care Services were provided to such retroactively disenrolled Subscriber, PMG shall receive payment under the provision of Section 4.06.

4.08.02 *Additions*. PacifiCare will use best efforts to discourage retroactive cancellations and additions of Subscribers. However, in the event that such retroactive enrollments occur for reasons beyond PacifiCare's control, including but not limited to, a) open enrollment

periods, b) household move, c) newborn Subscribers, d) PCP assignment changes within the participating Medical Group, PacifiCare shall allow such adjustments and retroactively adjust PMG's capitation as necessary, provided that the retroactive addition period shall not exceed ninety (90) days. In the event of allowable retroactive additions, a capitation payment shall be made to PMG, but PMG shall not be financially responsible for Medical Services not provided or authorized by PMG, or out of area emergency services provided during the retroactive period. PMG will, however, be financially responsible for in area emergency services provided during the retroactive period and all subsequent hospital services if they were provided or authorized by PMG.

4.08.03 *Acute Subscribers*. PacifiCare will not add or transfer Subscribers to PMG until the first day of the second month following the Subscriber's discharge from care for the following criteria, if at the time of request for transfer or addition the member is currently admitted, undergoing care or has an authorization for the following: Inpatient hospitalization, skilled nursing facility care, Home health, I.V. antibiotics, surgical/ trauma follow up, or other acute institutional care.

5. *COMPENSATION*

5.01 *CAPITATION PAYMENTS*—PacifiCare shall make monthly Capitation Payments to PMG as outlined in Attachment C, due and payable on the tenth (10th) day of the month for the current month's Medical Services.

In the event PacifiCare does not pay the monthly Capitation Payment within fifteen (15) days of the aforementioned due date, in addition to the monthly Capitation Payment, PacifiCare shall pay PMG the maximum allowed rate of interest per annum calculated daily until which date the past due sums are received.

5.02 *ADDITIONAL PAYMENTS*—PacifiCare and PMG agree to provide payments to each other in accordance with the terms of the following programs: Mammography Reimbursement Program, Maternity Payment Program and AIDs Stop-Loss Program as specified in Attachments C and E, respectively, incorporated in full herein by reference.

To the extent that each party owes an amount to the other party in the risk programs noted above, PMG agrees that PacifiCare shall combine the results of all applicable risk programs such that one aggregate payment is payable to or receivable from PMG. A fully detailed accounting of the results of each program shall accompany the aggregate payment or notice of amount due.

5.03 *ADEQUACY OF COMPENSATION*—PMG shall accept the payments specified in this Agreement as payment in full for all Medical Services provided Subscribers during each month for which such payments are to be received by PMG. In the event PacifiCare fails to make any payments to PMG as provided herein, whether from PacifiCare's insolvency or otherwise, Subscribers shall not be liable to PMG or its Member Physicians under any circumstances for Health Care Services. Surcharges for Health Care Services provided or arranged by PMG or Member Physicians are prohibited; upon notice of the existence of any such Surcharge, PacifiCare will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharges.

5.04 *OFFSETTING*—Except as may otherwise be specifically provided in this Agreement, PacifiCare shall have the right to offset any and all amounts owed by Medical Group to PacifiCare against amounts, including Capitation Payments, owed by PacifiCare to Medical Group. Before exercising such right, PacifiCare shall provide Medical Group with at least fifteen (15) calendar days prior written notice specifying the offset amount and reasonably demonstrating the reason for the proposed offset. If PacifiCare

receives payment or payment is made prior to the expiration of the fifteen (15) calendar day period or if PMG reasonably demonstrates its objection to the proposed offset, such amount will not be offset. This right to offset shall include, without limitation, PacifiCare's right to offset the following amounts owed to PacifiCare by Medical Group: (i) amounts owed by Medical Group under the incentive programs described in this Agreement and in the Product Attachments; (ii) amounts owed by Medical Group due to overpayments or payments made in error by PacifiCare (limited to one year from the date of service); (iii) amounts owed by Medical Group as a result of claims for Medical Group Services that PacifiCare may pay on behalf of Medical Group; (iv) amounts owed by Medical Group for PMG authorized Covered Services provided outside the Medical Group Service Area; and (v) amounts owed by Medical Group as a result of the outcome of the Member appeals and grievance procedure.

6. *TERM OF AGREEMENT*

6.01 *TERM*—The Initial Term of this Agreement shall be for sixty-one (61) months ("Initial Term") and the Commencement Date shall be December 1, 1995. After the Initial Term, a "Year" under this Agreement shall begin on January 1st and end on December 31st. The Term of this Agreement shall be automatically extended for one (1) year on each successive January 1st thereafter unless either party provides the other with written notice of such party's intention not to extend the term no less than one hundred twenty (120) days prior to the January 1 renewal date or until this Agreement is appropriately terminated by either party as provided in Section 7 herein. Upon renewal of the Initial Term and any subsequent term, the then applicable rates of compensation specified in this Agreement shall apply unless otherwise agreed upon by the parties in writing.

7. *TERMINATION*

7.01 *TERMINATION OF AGREEMENT WITH MATERIAL CAUSE*—Either party, as appropriate, may terminate this Agreement for material cause as set forth in Section 7.01.01 or 7.01.02 hereof subject to the notice and cure periods set out in Section 7.02 hereof. In the event either party shall desire to so terminate this Agreement, the terminating party shall give written notice of termination stating the actions of the other party constituting material cause for termination.

7.01.01 *CAUSE FOR TERMINATION OF AGREEMENT BY PMG*—The following shall constitute cause for termination of this Agreement by PMG:

a. *Non-Payment*—Failure by PacifiCare to pay Capitation Payments due to PMG hereunder within fifteen (15) days of the Capitation Payment due date or failure by PacifiCare to make any other payments due to PMG hereunder within forty-five (45) days of any such payment's due date.

b. *Revocation of Certification or License*—Revocation by the State of California or the United States Government of any certification or license of PacifiCare necessary for the performance of this Agreement.

c. *Breach of Material Term and Failure to Cure*—PacifiCare's breach of any material term, covenant, or condition and subsequent failure to cure said breach as provided in Section 7.02 hereof. The written notice of termination shall contain specific references as to the breaches which have caused such failure.

d. *Assignment of Rights, Interests and Benefits of the Agreement*—If PacifiCare's assignment of the rights, interests and benefits of this Agreement is not

mutually agreed to by PMG, such disapproval will be provided in writing and contain an explanation for withholding such approval.

7.01.02 *CAUSE FOR TERMINATION OF AGREEMENT BY PACIFICARE*—The following shall constitute cause or termination of this Agreement by PacifiCare:

a. *Financial Failure of PMG*—PacifiCare's reasonable determination of PMG's inability to provide or arrange for Health Care Services as described herein due to the likelihood of PMG's lack of financial resources, other than due to PacifiCare's non-payment of amounts due PMG hereunder. PMG shall have the opportunity to dispute such determination by PacifiCare by providing reasonable evidence and assurances of financial stability and capacity to perform under this Agreement.

b. *Failure to Provide Quality Medical Services*—Failure to maintain the standards set forth in Section 3.02 of this Agreement and such failure is not corrected consistent with the provisions of Section 7.02. The written notice of termination shall contain specific reference to the breaches which caused such failure. PacifiCare reserves the right to withdraw from PMG all or part of its Subscribers if the Health Care Services are not being properly provided or arranged for pursuant to this Agreement and such deficiencies are not corrected consistent with the provisions of Section 7.02 of this Agreement.

c. *Failure to Render Services*—Failure to provide Health Care Services to Subscribers as provided herein. The written notice of termination shall contain specific reference as to the breaches which have caused such failure.

d. *Breach of Material Term and Failure to Cure*—PMG's breach of any material term, covenant or condition of the Agreement and subsequent failure to cure said breach as provided in Section 7.02 of this Agreement. The written notice of termination shall contain specific reference to the breaches which have caused such failure.

7.02 *CURING PERIOD AND TERMINATION DATE*—A party receiving written notice of termination shall have thirty (30) days from the receipt of such notice to cure or otherwise eliminate the circumstances constituting cause for termination. If such party fails to cure or eliminate the circumstances constituting cause for termination within a thirty (30) day period, this Agreement shall terminate at the end of the thirty (30) day period.

7.03 *REPAYMENT UPON TERMINATION*—Within one hundred eighty (180) days of the effective date of termination of this Agreement as provided herein, an accounting shall be made by PacifiCare of monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) days of such accounting. Either party may request an independent audit of such PacifiCare accounting by a mutually acceptable independent certified public accountant and such audit shall be equally paid for by both parties requesting the audit. The parties agree to abide by the findings of such independent audit and appropriate payment by the appropriate party, if any, shall be made within thirty (30) days of such independent audit.

7.04 *TERMINATION NOT AN EXCLUSIVE REMEDY*—Any termination by either party pursuant to this Section 7 is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement.

7.05 *TERMINATION WITHOUT CAUSE*—Notwithstanding any other provision of this Agreement, either party may voluntarily terminate this Agreement at any time by giving at least one hundred twenty (120) days prior written notice to the other party.

8. *RECORDS, DATA COLLECTION CITATIONS AND RIGHT TO INSPECT RECORDS*

8.01 *RECORDS*—PMG shall maintain and provide such records and information as reasonably necessary for PacifiCare to properly administer the PacifiCare Medical and Hospital Plan consistent with state and federal law. The duties imposed by this Section 8.01 shall not terminate upon termination of this Agreement, whether by rescission or otherwise, and shall be in effect until the completion of the phase-out period pursuant to Section 3.09.

PMG shall maintain records and provide access to such information to PacifiCare or the California Commissioner of Corporations as may be necessary for the compliance by PacifiCare with the provisions of state and federal law and regulations promulgated thereto, and such records shall be retained by PMG for at least two (2) years following the provision of Health Care Services. This obligation is not terminated upon termination of this Agreement, whether by rescission or otherwise.

8.02 *CONFIDENTIALITY OF RECORDS*—PMG shall safeguard the confidentiality of Subscriber health records and treatment in accordance with all applicable state and federal laws, including, without limitation, the Privacy Act, as implemented by 45 Code of Federal Regulations 5(b) and the regulations promulgated thereunder

8.03 *DATA COLLECTION*—PMG shall maintain and provide to PacifiCare, on a timely basis, the utilization data more particularly described in the PacifiCare Provider Policy and Procedures Manual for the effective management of

PacifiCare's health care delivery system. Among the reports which PMG shall use best efforts to provide to PacifiCare is encounter data which consists of an itemization of PMG's paid claims or pre-paid capitated services provided to PacifiCare Subscribers. This information shall be submitted in a manner consistent with the PacifiCare Policy and Procedure Manual requirements and in a mutually agreed upon format. PacifiCare shall impose a penalty for failure to submit such encounter data, which was reasonably within the control of PMG to submit, within ninety (90) days of the date of service by deducting one percent (1%) of PMG's monthly capitation for each month PMG fails to submit such data.

8.04 *RIGHT TO INSPECT*—PMG shall provide access at reasonable times upon demand by PacifiCare, or any governmental regulatory agency responsible for the administration of health care service plans, to inspect facilities, equipment, books and records relating to the performance of this Agreement, including, without limitation, Subscriber patient records, financial records pertaining to the income received by PMG for Health Care Services rendered to Subscribers. Unless otherwise required by law, PacifiCare shall provide PMG with a seventy-two (72) hour prior written notice of any such inspection.

8.05 *FINANCIAL STATEMENTS*—PMG shall provide to PacifiCare, upon request, copies of its audited annual financial statements, which shall include a balance sheet, statement of income, and a statement of cash flow (the "financial statements") prepared in accordance with generally accepted accounting principles.

8.06 *TRANSFER OF MEDICAL RECORDS UPON TERMINATION*—Upon the effective date of termination of this Agreement and, if applicable, upon the expiration of the phase-out period set forth in Section 3.09, at PacifiCare's request, PMG shall copy all active PacifiCare Subscriber patient medical files in PMG's possession and forward such

files to another provider of Health Care Services designated by PacifiCare, provided such copying and forwarding is not otherwise objected to by Subscribers. The copies of such medical files may be in summary form. The cost of copying the patient medical files shall be borne by Medical Group if Medical Group terminates this Agreement or by PacifiCare if PacifiCare terminates this Agreement. PMG and PacifiCare shall cooperate in maintaining the confidentiality of such confidential and proprietary information and trade secrets at all times.

9. *EXCLUSIVITY*

9.01 *HOSPITAL EXCLUSIVE PROVIDER OF HOSPITAL SERVICES*—In recognition of the need for centralized coordination of Hospital Services to Subscribers to ensure continuity and quality of care, PMG agrees, subject to the limitations stated below, to require its individual physicians to use Hospital as its exclusive provider of Hospital Services for all Subscribers eligible to receive Hospital Services in the PMG Service Area. This exclusivity provision is subject to the following exceptions:

9.01.01 *Emergency Services*—Subscribers admitted for Emergency Services through other hospitals, whether in or out of the PMG Service Area.

9.01.02 *Unavailable Hospital Services*—Subscribers requiring Hospital Services not available at Hospital, including specialty Hospital Services and those which cannot be provided due to ethical principles of Hospital.

9.01.03 *Unauthorized Admissions*—Unauthorized Subscriber admissions to health care facilities within the PMG Service Area for Hospital Services.

9.01.04 *Subscriber Requests for Treatment at Other Facilities*—PMG may grant Subscriber requests for treatment or for transfer to another facility due to

Medical Necessity or impairment of the Hospital/ Subscriber relationship. PMG shall exercise reasonable efforts in discouraging such Subscriber requests unless Subscriber can show just cause for such request. Prior to any transfer, the PMG must deem the transfer to be medically safe and the Hospital must approve payment for services.

9.02 *UTILIZATION OF PMG BY PACIFICARE*—Nothing in this Agreement shall be construed to require PacifiCare to assign any minimum or maximum number of Subscribers to PMG, nor to require PacifiCare to utilize the Health Care Services of PMG for any or all Subscribers in the PMG Service Area.

10. *GOVERNING LAW AND DISPUTE RESOLUTION*

10.01 *GOVERNING LAW*—This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California, and the United States and all regulations promulgated pursuant thereto. Any provisions required to be in this Agreement by any of the above Acts and regulations shall bind PacifiCare and PMG whether or not expressly provided in this Agreement

10.02 *DISPUTES BETWEEN PMG AND SUBSCRIBER NOT GOVERNED BY AGREEMENT*—Any controversies or claims between PMG and Subscriber arising out of PMG's performance of this Agreement are not governed by this Agreement. PMG and Subscriber may seek any appropriate legal action to resolve such controversy or claim deemed necessary.

In the event of dispute between PMG and a Subscriber and upon mutual agreement between PMG and such Subscriber, PacifiCare agrees to make available the Subscriber Grievance

Resolution Process described in the PacifiCare Health Plan Agreement for resolution of such dispute. In such instance, the decision of the PacifiCare Subscriber Satisfaction Committee and Board of Directors shall not be binding upon the parties except upon agreement between PMG and the Subscriber. Nor shall such grievance be subject to binding arbitration except upon agreement between the parties. Should PMG and Subscriber fail to resolve the grievance, PMG and Subscriber may seek any appropriate legal action deemed necessary by such party.

10.03 *PAYMENT DISPUTES BETWEEN PMG AND CONTRACTING PROVIDER PHYSICIANS*—In the event PMG fails to make a payment to a Contracting Provider physician within sixty (60) days of the submission of the bill by Contracting Provider physician to PMG and the validity and the amount of the submitted bill are undisputed, PacifiCare may, after fifteen (15) day prior notification, elect to pay the Contracting Provider physician on behalf of PMG and deduct such payment from PMG's next monthly Capitation Payment.

Should a dispute concerning a claim for payment for Medical Services rendered to Subscribers arise between PMG and a Contracting Provider physician who is a Participating Medical Provider, PMG or the Contracting Provider physician, may submit a written complaint to PacifiCare. The complaint shall describe the disputed claim and the basis for the amounts claimed and include the applicable written agreement between PMG and the Contracting Provider physician. PacifiCare shall investigate the complaint and make a determination of whether or not the claim is valid and should be paid. In the event PacifiCare determines that PMG owes any amount to Contracting Provider physician, PMG shall make such payment within thirty (30) days of PacifiCare's determination. If PMG fails to pay the amount due within this thirty (30) day period,

PacifiCare may deduct the amount owed from PMG's next monthly capitation payment. This amount will temporarily be placed in an account (the "Claims Dispute Account") which shall be established by PacifiCare. If PMG or Contracting Provider physician wishes to contest PacifiCare's determination, either may do so by initiating an action for binding arbitration and notifying PacifiCare of such initiation within thirty (30) days of PacifiCare's determination. If PMG or Contracting Provider physician fails to request arbitration within thirty (30) days or if the arbitration affirms PacifiCare's decision that amounts are owing from PMG to Contracting Provider physician, PacifiCare shall release from the Claims Dispute Account the amount owing the physician. If the arbitration results in a decision that no money or a lesser amount than was determined by PacifiCare is owing to Contracting Provider physician, PacifiCare shall release to PMG the amounts which were erroneously withheld from PMG's Capitation Payment.

In the event this Agreement has been terminated prior to PacifiCare's investigation and written determination and PacifiCare's investigation results in a determination that PMG owes money to Contracting Provider physician, PacifiCare may elect to pay Contracting Provider physician on behalf of PMG and seek reimbursement from PMG through arbitration as described in this Section.

10.4 *ARBITRATION*—Any controversy, dispute or claim arising out of the interpretation, performance, or breach of this Agreement which is not resolved pursuant to the Provider Dispute Resolution Procedure specified above shall be resolved by binding arbitration at the request of either party, in accordance with the Commercial Rules of the American Arbitration Association. Such arbitration shall occur in Sacramento, California unless the parties mutually agree to have such proceeding in some other locale. The arbitrators shall apply California Substantive law and federal

substantive law where state law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with the provisions of California law, and the arbitrator(s) selected shall have the power to enforce the rights, remedies, duties, liabilities and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court of competent jurisdiction of the State of California. The provisions of California law concerning the right to discovery and the use of the depositions in arbitration are incorporated herein by reference and made applicable to this Agreement.

The arbitrators shall have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages shall not be awarded. The arbitrators shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. The arbitrators shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. The arbitrators shall not have the power to commit errors of law or legal reasoning.

Notwithstanding the above, in the event either Medical Group or PacifiCare wishes to obtain injunctive relief or a temporary restraining order, such party may initiate an action for such relief in a court of general jurisdiction in the State of California. The decision of the court with respect to the requested injunctive relief or temporary restraining order shall be subject to appeal only as allowed under California. However, the courts shall not have the authority to review or grant any request or demand for damages.

11. *NOTICE*

11.01 *NOTICE*—Any notice required to be given hereunder shall be in writing either delivered personally or sent

by registered or certified mail, return receipt requested, to either PacifiCare or PMG at the addresses listed below, or at such other addresses as either PacifiCare or PMG may hereafter designate to the other.

To PacifiCare:
PacifiCare of California
P.O. Box 6006
Cypress, California 90630-0006
Attention: President

To Sutter Independent Physicians:
Sutter Independent Physicians
~~3800 L Street~~ [Handwritten: *10860 Grid Center Drive, 3rd Floor*]
Sacramento, CA ~~95816~~ [Handwritten: *95670]*
Attention: ~~Chief Executive Officer~~ ~~Administration~~ [Handwritten: *Chief Operations Officer*]

Copy to:
Sutter Health Managed Care Department
P.O. Box 160727
Sacramento, CA 95816
Attention: Contract Manager

All notices shall be deemed given on the date of delivery if delivered personally.

12. *MISCELLANEOUS*

12.01 *PROTECTION OF SUBSCRIBER*—PMG may not impose any limitations on the acceptance of Subscribers for care or treatment that it does not impose on other patients of the PMG. Neither PacifiCare, PMG nor Hospitals may request, demand, require or seek directly or indirectly the

transfer, discharge, or removal of any Subscriber for reasons of Subscriber's need for, or utilization of, Medically Necessary Health Care Services, except in accordance with the procedures established for such action. PMG shall not refuse or fail to provide Medically Necessary Health Care Services to any Subscriber. Procedures for removal, discharge or transfer of Subscribers shall be mutually agreed upon between PMG and PacifiCare consistent with the PacifiCare Health Plan.

12.02 *OTHER AGREEMENTS*—Nothing in this Agreement shall prevent PacifiCare and PMG from contracting with each other for provision of services not covered by this Agreement.

12.03 *GOVERNING LAW*—PacifiCare, PMG and this Agreement are subject to the laws of the State of California and the United States of America, specifically: the California Knox-Keene Act and the regulations promulgated thereunder by the California Department of Corporations, and the Health Maintenance Organization Act of 1973 and the regulations promulgated thereunder by the United States Department of Health and Human Services.

PMG shall maintain such records and provide such information to PacifiCare or the California Commissioner of Corporations as may be necessary for the compliance by PacifiCare with the provisions of the above Acts and regulations, and such records shall be retained by PMG or at least two (2) years following the provision of Health Care Services. This obligation is not terminated upon termination of this Agreement, whether by rescission or otherwise.

Any provisions required to be in this Agreement by any of the above Acts and regulations shall bind PacifiCare and PMG whether or not expressly provided in this Agreement.

12.04 *REFUSAL BY PHYSICIAN*—PMG of any of its Member Physicians may refuse Health Care Services to a Subscriber assigned to PMG for violent, disruptive, or non-compliant behavior with Member Physicians and/or staff of any physician subject to prior approval by PacifiCare for which approval shall not be unreasonably withheld. It shall remain the responsibility of PMG to assure that Subscribers who are assigned to PMG and who are not violent, disruptive, or non-compliant with Member Physicians and or staff of any physician, receive Health Care Services consistent with the terms of this Agreement.

12.05 *CONFIDENTIAL AND PROPRIETARY INFORMATION*

12.05.01 *Information Confidential and Proprietary to PacifiCare*—PMG acknowledges that all PacifiCare Subscribers participating in a PacifiCare Health Plan individually or through an employer group and receiving Health Care Services shall be Subscribers of PacifiCare. Subscriber and employer group information shall include, without limitation, the names, addresses and telephone numbers of all Subscribers, the names, addresses and telephone numbers of employer group employees responsible for health benefits and the officers and directors of such employer groups; member, employer and administrative service manuals and all forms related thereto; and records, files (other than patient medical files) and lists contained in PMG and PacifiCare files.

PMG acknowledges that all such information is confidential and proprietary to PacifiCare and that such Subscriber and employer group information contains valuable trade secrets of PacifiCare.

All PacifiCare Subscriber agreements and the information contained therein regarding PacifiCare, PMG, employer groups, Subscribers or the financial arrangements between a hospital, PMG and PacifiCare is confidential and proprietary to PacifiCare.

PMG shall maintain all Subscriber information and other PacifiCare trade secret information confidential. PMG shall not disclose or use any confidential and proprietary information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement; provided, however, that PMG may use the name, address and telephone number of other medical information of a PacifiCare Subscriber if Medically Necessary for the proper treatment of such Subscriber or upon express prior written permission of PacifiCare.

12.05.02 *Information Confidential and Proprietary to PMG*—All PMG information shall be considered proprietary to PMG and confidential and may contain trade secrets of PMG ("PMG Information"). PacifiCare shall maintain PMG Information confidential. PacifiCare shall not disclose or use any PMG Information for its own benefit either during the term of this Agreement or after the effective date of termination of this Agreement without the consent of PMG. PacifiCare shall cooperate with PMG in maintaining the confidentiality of PMG Information at all times.

12.05.03—*Solicitation of PacifiCare Subscribers or Employer Groups*

12.06 *CONFIDENTIALITY OF THIS AGREEMENT*—To the extent reasonably possible, each party agrees to maintain this Agreement as a confidential document and not to disclose the Agreement or any of its terms without the approval of the other party.

12.07 *ASSIGNMENT*—This Agreement and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by PMG or PacifiCare and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein by subcontracted or delegated without the prior written consent of other party. However, PacifiCare and PMG may assign this Agreement and its rights, interests and benefits hereunder to any entity which has at least majority control of said party, or to any entity of which PacifiCare or PMG has at least majority control, or to an affiliate, upon ninety (90) days' prior written consent to the other party.

12.08 *INVALIDITY OF SECTIONS OF THIS AGREEMENT*—The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

12.09 *WITHDRAWAL OF SUBSCRIBERS BY PACIFICARE*—PacifiCare reserves the right to withdraw from PMG all or part of the Subscribers from PMG whose Health Care Services are not being properly provided pursuant to this Agreement. PacifiCare shall provide written notice to PMG of such withdrawal and the reasons therefore. PacifiCare shall then allow PMG ninety (90) days from the date of such notice to correct deficiencies. PacifiCare and PMG shall work together to resolve such noted deficiencies. If such deficiencies are not corrected to PacifiCare's satisfaction within said period, PacifiCare may withdraw its Subscribers as provided in this Section 12.09 and remove PMG's name from PacifiCare's marketing materials.

12.10 *TRANSFER OF SUBSCRIBERS*—Subscriber requests for transfer from PMG shall be in writing and subject to approval by PacifiCare based on the criteria set forth in the PacifiCare Policy and Procedures Manual. PacifiCare reserves the right to transfer a Subscriber for any reason.

PMG may request transfer of Subscribers for cause, or if the capacity of PMG is over burdened such that the provision of Medical Services as required pursuant to this Agreement adversely is affected.

12.11 *CAPTIONS*—Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

12.12 *AMENDMENT*—This Agreement may be amended or modified only by mutual written consent of the parties. Notwithstanding the foregoing sentence, PacifiCare may amend this Agreement upon sixty (60) days written notice to PMG in order to maintain compliance with applicable federal and state laws. Any such amendment which affects a legally required duty or responsibility of PMG and has a material adverse economic effect upon PMG as reasonably demonstrated by PMG to PacifiCare, shall be subject to the provisions of Section 12.13 below.

12.13 *MODIFICATIONS OF THIS AGREEMENT AND/OR PACIFICARE PROVIDER AND PROCEDURES MANUAL AND/OR PACIFICARE HEALTH PLAN*—Anything to the contrary herein notwithstanding, in the event of any material modification of this Agreement and/or the PacifiCare Provider and Procedures Manual and/or the PacifiCare Health Plan, including the benefit plan, that (i) affects a material duty or responsibility of PMG, and(ii) causes a material economic detriment to PMG. PMG and PacifiCare shall seek to agree to an amendment to this Agreement which satisfactorily addresses the effect on PMG's material duty or responsibility and reimburses the material economic detriment caused to PMG. In the event such an agreement cannot be reached within sixty (60) days after the date PacifiCare gives PMG written notice of such modification, such modification shall not be effective.

12.14 *TERMS; SECTIONS*—Unless otherwise indicated, all terms in any appropriate attachments, addendum's and amendments hereto shall have the same meaning attributed to such terms in the body of this Agreement and reference to section numbers are to the appropriate sections of this Agreement.

12.15 *PMG's AUTHORIZED REPRESENTATIVE*—Unless otherwise indicated in writing to PacifiCare, PMG warrants and authorizes its Chief Executive Officer to act as its fully authorized representative to represent PMG and Member Physicians in this Agreement and to receive any and all communications and notices hereunder.

12.16 *WAIVER*—Any failure of a party to insist upon strict compliance with any term, undertaking, or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be signed and dated by the party executing the waiver.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in _____, California, on _____, 19__.

PACIFICARE OF CALIFORNIA	SUTTER INDEPENDENT PHYSICIANS
BY: /s/ _____	BY: /s/ _____
TITLE: [Handwritten: *Managing Director*] _____	TITLE: President, SIP Board
	DATE: 9/17/98 _____
DATE: [Handwritten: *10/20/98*] _____	

UNITED HEALTHCARE OF FLORIDA, INC.
MEDICAL GROUP PARTICIPATION AGREEMENT

THIS AGREEMENT, effective [handwritten: 8/1/98], 1998 ("Effective Date"), is between United HealthCare of Florida, Inc. ("Plan") and Community Orthopedics & Pain Management, Inc. ("Medical Group") and sets forth the terms and conditions under which Medical Group shall participate in one or more networks of providers developed by Plan to render health care services to Members, as defined in this Agreement. This Agreement shall apply to the South Florida Region whose service area may change from time-to-time. On the Effective Date, this Agreement supersedes and replaces in the South Florida Region any existing agreements between the parties related to the provision of health care services to Members. This Agreement also supersedes and replaces any existing agreements between Medical Group and the following entities to the extent such agreements relate to the provision of health care services to Members and to the extent such entities sponsor, issue, or administer a Benefit Contract, as defined in this Agreement: -CAC- United HealthCare Plans of Florida, Inc., -CAC- Ramsay Health Plans, Inc., United HealthCare Plans of Florida, Inc. The MetraHealth Insurance Company, The Travelers Insurance Company, Metropolitan Life Insurance Company, and United Health and Life Insurance Company.

SECTION 1
DEFINITIONS

Benefit Contract: Benefit plan that includes health care coverage, is sponsored, issued, or administered by Payor, and contains the terms and conditions of a Member's coverage.

Customary Charge: Fee for health care services charged by Medical Group that does not exceed the fee Medical

Group would charge any other person regardless of whether the person is a Member.

Health Services: Health care services and supplies covered by the Member's Benefit Contract.

Medical Group Physician: Doctor of medicine or osteopathy, duly licensed and qualified under the laws of the State of Florida, who practices as a shareholder, partner, or employee of Medical Group, and who has executed a Medical Group Physician Participation Addendum, the form of which is attached to this Agreement.

Member: Individual who is properly covered under a Benefit Contract.

Member Expenses: Amounts that are the Member's responsibility to pay Medical Group in accordance with the Member's Benefit Contract, including copayments, coinsurance, and deductibles.

Participating Provider: Health care professional or facility, including Medical Group, that has a written participation agreement in effect with Plan, directly or through another entity, to provide Health Services to selected groups of Members.

Payor: Entity or person authorized by Plan to access one or more networks of Participating Providers developed by Plan and that has the financial responsibility for payment of Health Services covered by a Benefit Contract.

Primary Care Physician: Doctor of medicine or osteopathy, or another health care professional as required by applicable statutes and regulations, who is duly licensed and qualified under the laws of the State of Florida, has met Plan criteria to be classified as a Primary Care Physician, and is a Participating Provider of primary care Health Services.

Referral Authorization: Approval by a Member's Primary Care Physician in a format determined by Payor, which may be an electronic format, for a health care professional or facility to render certain Health Services to the Member.

Referral Physician: Doctor of medicine or osteopathy who is a Participating Provider, who is not a Primary Care Physician, and to whom a Member is referred by a Primary Care Physician for the provision of certain Health Services.

SECTION 2
NETWORKS OF PARTICIPATING PROVIDERS

Medical Group shall provide Health Services to Members covered under the Benefit Contract types described in Exhibit 1, which may be modified from time to time by Plan upon written notice to Medical Group, and which includes, but is not limited to, Benefit Contracts that offer a network of Participating Providers.

When Benefit Contracts offer a network of Participating Providers the product name will appear on the Member's identification card and the Members will receive a provider directory listing all Participating Providers. Members covered under these Benefit Contract types are incented to receive services from Participating Providers. Such incentives may include, but are not limited to, a higher level of coverage and/or the potential reduction or elimination of Member Expenses.

SECTION 3
DUTIES OF MEDICAL GROUP

3.1 *Member Status*. To determine whether an individual is a Member and, therefore, entitled to receive Health Services, Medical Group shall ask the individual to present his/her identification card, which shall be provided to all Members by Payors, unless because of the type of Benefit Contract under which the Member has coverage no

identification card applies. In addition, Medical Group may contact Plan to obtain Plan's most current information on the individual as a Member. However, Medical Group acknowledges that such information is subject to change retroactively if Plan does not receive proper and timely notification regarding termination of a Member's coverage, as a result of the Member's final decision regarding continuation of coverage pursuant to state and federal laws, or if eligibility information Plan receives on the individual is later proven to be false. If Medical Group provides health care services to an individual and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Medical Group may then directly bill the responsible party for such services.

3.2 *Provision of Health Services.* Medical Group shall provide Health Services to all Members as Medical Group's patient load and appointment calendar permit and shall accept Members as new patients on the same basis as Medical Group is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age, physical or mental health status, or on any other basis deemed unlawful under federal, state, or local law. At all times, Medical Group shall require employed or subcontracted health care professionals and facilities, including, but not limited to, Medical Group Physicians, to comply with the protocols and requirements of Plan and Payor and the requirements of all applicable regulatory authorities. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract. Medical Group warrants and represents that it has the authority to enter into this Agreement on behalf of all Medical Group Physicians and shall assure that Medical Group Physicians comply with all applicable terms of this Agreement.

3.3 *Utilization Management, Quality Improvement, and Other Plan or Payor Programs.* Medical Group shall cooperate with all credentialing and recredentialing processes and all utilization management, quality improvement, peer review, Member grievance, onsite review, or other similar Plan or Payor programs.

3.4 *Protocols.* Medical Group shall comply with protocols of Plan or Payor, including, but not limited to the following:

1. Refer Members only to other Participating Providers, unless otherwise authorized by Plan or Payor.
2. Be bound by any provider manual and credentialing plan, as modified from time-to-time by Plan or Payor.
3. Obtain prior authorization for certain Health Services as defined by Plan or Payor.
4. Follow approved billing procedures of Plan or Payor, as appropriate.
5. If Medical Group is composed of one or more Primary Care Physicians, Medical Group shall provide or arrange for the provision of advice and assistance to Members in emergency situations 24 hours per day, seven days per week.
6. If the Member's Benefit Contract requires the Member to receive certain Health Services from or upon referral by a Primary Care Physician, all Referral Physicians must adhere to the following additional protocols when those Heath Services are provided:

a. Referrals to other Participating or non-Participating Providers must first be authorized by the Member's Primary Care Physician.

b. Health Services must be provided pursuant to the terms and limitations of the Referral Authorization issued by or on behalf of the Member's Primary Care Physician.

7. Medical Group shall comply with the following requirements when admitting Members to a hospital:

a. Admit Members on the day of surgery, unless the Member's medical condition requires otherwise and Medical Group Physician has obtained prior authorization from Plan or Payor, as appropriate.

b. Notify Plan or Payor, as appropriate, by telephone at least 48 hours prior to a scheduled admission of a Member.

c. Notify Plan or Payor, as appropriate, immediately if Medical Group Physician admits a Member to a hospital for an emergency or for observation.

d. If the Medical Group Physician providing the Heath Services is a Referral Physician, the Medical Group Physician must also notify the Member's Primary Care Physician of all admissions in accordance with the above time frames.

Failure to comply with the above may result in denial of payment to Medical Group and/or termination of this Agreement. If any payment to Medical Group is denied due to Medical Group's failure to comply with the above

protocols, Medical Group shall not bill the Member for the denied amounts.

3.5 *Medical Group Physicians*. Acceptance of Medical Group as a Participating Provider is subject to the requirement that all physicians that join Medical Group become Participating Providers. However, Medical Group understands that all current and future physicians that join Medical Group must go through the Plan credentialing process before they are accepted as Participating Providers. Medical Group also understands that Medical Group Physicians may be individually terminated as Participating Providers pursuant to Section 9.4 of this Agreement. Medical Group shall notify Plan of all Medical Group Physicians who are added to the staff of Medical Group as well as those who are no longer on the staff of Medical Group.

3.6 *Hospital Privileges*. Medical Group and Medical Group Physicians agree to maintain privileges at Plan's participating hospitals and to notify Plan of any suspension, revocation, condition, limitation, qualification, or other material restriction of Medical Group Physician's staff privileges at any licensed hospital.

3.7 *Medical Group Locations*. Medical Group shall provide Health Services at the office locations set forth in Exhibit 2, as amended by Plan from time-to-time. Plan shall provide written notification to Medical Group of any changes to Plan's current service area. Medical Group shall provide Plan with 60-days prior written notification of any changes in its office locations.

SECTION 4
PAYMENT PROVISIONS

4.1 *Payment*. For the provision of Health Services to a Member, Payor shall pay Medical Group the applicable amounts set forth in the attached appendices. The obligation

for payment under this Agreement for Health Services rendered to a Member is solely that of Payor. Unless otherwise specified in the appendices or required by applicable statutes and regulations, Payor shall make payment to Medical Group within 30 days following Plan's receipt of all information necessary to process the claim.

Medical Group shall accept as payment in full for Health Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges which result from Payor's reimbursement methodologies. In no event shall Medical Group bill a Member for the difference between Customary Charges and the amount Medical Group has agreed to accept as full reimbursement under this Agreement. Medical Group may collect Member Expenses from the Member. If Payor denies payment for services rendered by Medical Group on grounds that the services are not medically necessary or charges for services not covered under the Member's Benefit Contract, as defined in the Member's Benefit Contract, Medical Group shall not collect payment from the Member for the services unless Medical Group first obtains the Member's written consent.

4.2 *Submission of Claims*. Medical Group shall submit claims for Health Services to Plan in a manner and format prescribed by Plan, which may be an electronic format. All information necessary to process the claims must be received by Plan no more than 90 days from the date the Health Services are rendered. Medical Group agrees that claims received after this time period may be rejected for payment, at Plan's and/or Payor's discretion. An exception to the 90 day claims submission deadline will be made if, as soon as possible but within the 90 days, Medical Group gives Plan written notice that the deadline can not be met due to coordination of benefits with another payor.

Unless otherwise directed by Plan, Medical Group shall submit claims using current HCFA 1500 or UB92 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue, and HCPCS coding. Medical Group shall include in a claim the Member number, Customary Charges for the Health Services rendered to a Member during a single instance of service, Medical Group's federal tax identification number, and/or other identifiers requested by Plan. Medical Group shall not bill the Member for Health Services if Medical Group fills to submit claims in accordance with the above provisions.

Payor shall have the right to make, and Medical Group shall have the right to request, corrective adjustments to a previous payment; provided, however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

4.3 *Coordination of Benefits*. Medical Group shall be paid in accordance with Payor's coordination of benefits rules.

4.4 *Financial Responsibility*. Plan shall notify Medical Group in writing if Plan determines that a Payor has failed to maintain its responsibility to pay for services rendered. Any services which have been rendered by Medical Group prior to and after such notification, and which were not paid for by Payor, shall be considered ineligible for reimbursement under this Agreement and Medical Group may bill the Member directly for such services.

4.5 *Continuation of Benefits and Member Protection Provision*. This provision applies in instances where required by applicable statutes and regulations:

Medical Group agrees that in the event of Payor's insolvency or other cessation of operations, benefits to Members will continue and Medical Group will continue to provide Health Services to Members through the period for

which premium has been paid and benefits to Members confined in an inpatient facility on the date of Payor's insolvency or other cessation of operations will continue and Medical Group will continue to provide Health Services to Members until their discharge.

This provision supersedes and replaces the financial responsibility section when Plan is the Payor, when required by a specific Payor other than Plan, or when required pursuant to applicable statutes and regulations:

In no event, including, but not limited to, non-payment by Payor for Health Services rendered to Members by Medical Group, insolvency of Payor, or breach by Plan of any term or condition of this Agreement, shall Medical Group bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Health Services eligible for reimbursement under this Agreement; provided, however, that Medical Group may collect from the Member any Member Expenses or charges for services not covered under the Member's Benefit Contract.

The provisions of this section shall (1) apply to all Health Services rendered while this Agreement is in force; (2) with respect to Health Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members, and (4) supersede any oral or written agreement, existing or subsequently entered into, between Medical Group and a Member or person acting on a Member's behalf, that requires the Member to pay for such Health Services.

SECTION 5
LIABILITY OF PARTIES, LAWS, REGULATIONS, AND LICENSES

5.1 *Liability Insurance.* Medical Group shall procure and maintain, at Medical Group's sole expense, medical malpractice insurance in the amounts of $1,000,000 per occurrence and $3,000,000 aggregate, and comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and aggregate. Medical Group shall also require that all health care professionals employed by or under contract with Medical Group to render Health Services to Members procure and maintain malpractice insurance, unless they are covered under Medical Group's insurance policies. Medical Group's and other health care professionals' medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by Plan. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Medical Group shall submit to Plan written evidence of insurance coverage.

5.2 *Laws, Regulations*, and Licenses. Medical Group shall maintain all federal, state, and local licenses, certifications, and permits, without material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Health Services are provided and shall comply with all applicable statutes and regulations. Medical Group shall also require that all health care professionals employed by or under contract with Medical Group to render Health Services to Members, including covering physicians, comply with this provision.

SECTION 6
NOTICES

Medical Group shall notify Plan within ten days of knowledge of the following:

1. Changes in liability insurance carriers, termination of, renewal of, or any other material changes in liability insurance, including reduction of limits, erosion of aggregate, changes in retention, or non-payment of premium.

2 Action which may result in the suspension, revocation, condition, limitation, qualification, or other restriction on a Medical Group Physician's licenses, certifications, or permits by any government under which a Medical Group Physician is authorized to provide health care services.

3. Any suspension, revocation, condition, limitation, qualification, or other restriction of a Medical Group Physician's staff privileges at any licensed hospital, nursing home, or other facility at which a Medical Group Physician has staff privileges during the term of this Agreement.

4. Change in name, ownership, or federal tax identification number.

5. Indictment, arrest, or conviction for a felony or for any criminal charge related to the practice of Medical Group's profession.

6. Conduct which creates an imminent danger to a Member.

Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. The

parties shall provide each other with proper addresses of all designees that should receive certain notices or communication instead of that party.

SECTION 7
RECORDS

7.1 *Confidentiality of Records*. Plan and Medical Group shall maintain the confidentiality of all Member records in accordance with any applicable statutes and regulations.

7.2 *Maintenance of and Plan Access to Records*. Medical Group shall maintain adequate medical, financial, and administrative records related to Health Services rendered by Medical Group under this Agreement. In order to perform its utilization management and quality improvement activities, Plan shall have access to such information and records, including claims records, within 14 days from the date the request is made, except that, in the case of audit by Plan such access shall be given at the time of the audit. If requested by Plan, Medical Group shall provide copies of such records free of charge. Unless a longer time period is required by applicable statutes or regulations, Plan shall have access to and the right to audit information and records during the term of this Agreement and for five years following its termination or longer if records are under review or audit, until such review or audit is completed. It is Medical Group's responsibility to obtain any Member consent required in order to provide Plan with requested information and records or copies of records.

7.3 *Government and Accrediting Agency Access to Records*. The federal, state, and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance, and any of their authorized representatives shall have access to, and Plan and Medical Group are authorized to release, in accordance with applicable statutes and regulations, all information and

records or copies of such, within the possession of Plan or Medical Group, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes, or regulations applicable to Plan, Payor, or Medical Group.

SECTION 8
RESOLUTION OF DISPUTES

The parties shall work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if either party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association, in no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Dade County, Florida. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award extra contractual damages of any kind, including punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Plan procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Medical Group before Medical Group may invoke its right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

SECTION 9
TERM AND TERMINATION

9.1 *Term*. This Agreement shall begin on the Effective Date, shall remain in effect for one year, and shall

automatically renew for successive one-year terms until terminated as provided below.

9.2 *Termination*. This Agreement may be terminated as follows:

1. by mutual agreement of Plan and Medical Group.
2. by either party upon 90 days prior written notice to the other party.
3. by either party, in the event of a breach of this Agreement by the other party, upon 30 days prior written notice to the other party.
4. by Plan, immediately upon written notice to Medical Group, due to Medical Group's loss or suspension of licensure, imposition of sanctions, or certification or loss of insurance.
5. by Medical Group upon 60 days prior written notice to Plan due to an amendment made to this Agreement pursuant to Section 10.1.

9.3 *Termination of Medical Group Physician*. Plan may require Medical Group to terminate the status of any individual Medical Group Physician as a Participating Provider as follows:

1. In the event of a material breach of this Agreement by Medical Group Physician, upon 30 days prior written notice to Medical Group and Medical Group Physician.
2. Immediately upon written notice to Medical Group and Medical Group Physician due to the Medical Group Physician's loss or suspension of licensure or certification, imposition of sanctions, or loss of liability insurance required under this Agreement.
3. In accordance with the Plan credentialing process.

4. Due to a conviction for any criminal charge related to the practice of Medical Group Physician's profession.

5. Due to conduct which creates an imminent danger to a Member.

9.4 *Regulatory Termination*. In addition to the above, the following shall apply with respect to arrangement between Plan and Medical Group or any individual Medical Group Physician:

1. This Agreement may be terminated immediately upon issuance of an order by the Florida Department of Insurance ("DOI").

2. Nonpayment by Payor shall not be a valid reason for avoiding any required notice period for termination of the Agreement.

3. In addition to any prior notice Medical Group, Medical Group Physician and Plan are required to provide pursuant to this section, Medical Group, Medical Group Physician and Plan shall also give the same written notice of such termination to the DOI, when required by law.

Medical Group shall receive notice of termination by Plan of any Medical Group Physician. Termination of any individual Medical Group Physician shall not constitute termination of the entire Agreement.

In the event of the termination of Medical Group Physician, that Medical Group Physician shall not provide Health Services to Members after the effective date of termination, unless otherwise agreed to by Plan in writing.

9.5 *Information to Members*. Medical Group acknowledges the right of Plan to inform Members of Medical Group's termination and agrees to cooperate with Plan in deciding on the form of such notification. In addition

to any prior notice Medical Group and Plan are required to provide pursuant to this section, Medical Group and Plan shall also give at least 60 days prior written notice of such termination to the DOI, when required by law.

9.6 *Obligations Upon Termination*. Upon the termination of this Agreement or termination of any Medical Group Physician, the rights and obligations of the parties shall cease, except as otherwise provided by this Agreement. When medically necessary, Medical Group Physician will continue to provide Health Services to Members for 60 days if the Member has a life-threatening condition or a disabling and degenerative condition or until completion of postpartum care if the Member is in the third trimester of pregnancy. For such continued care, Plan, Medical Group, and Medical Group Physician shall be bound by the terms of this Agreement.

SECTION 10
MISCELLANEOUS

10.1 *Amendment*. Plan may amend this Agreement by sending a copy of the amendment to Medical Group at least 30 days prior to its effective date. The signature of Medical Group shall not be required. Renegotiation of the rates in this Agreement shall be upon the mutual consent of the parties. Plan may also amend this Agreement to comply with the requirements of state and federal regulatory authorities and shall give written notice to Medical Group of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Medical Group shall not be required.

10.2 *Assignment*. Plan may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with Plan. Medical Group may assign any of its rights and responsibilities under this Agreement to any person or entity

only upon the prior written consent of Plan, which consent shall not be unreasonably withheld.

10.3 *Administrative Responsibilities*. Plan may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, Payor or is designee. In addition, certain Payor responsibilities may actually be performed by its designee.

10.4 *Relationship Between Plan and Medical Group*. The relationship between Plan and Medical Group is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, or joint venture.

10.5 *Name, Symbol and Service Mark*. During the term of this Agreement, Medical Group. Plan, and Payor shall have the right to use each other's name solely to make public reference to Medical Group as a Participating Provider. Medical Group, Plan, and Payor shall not otherwise use each other's name, symbol, or service mark without prior written approval.

10.6 *Confidentiality*. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party including but not limited to financial statements, business plans, protocols. and programs; except that Medical Group may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates and Plan may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Contract any may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.7 *Communication*. Plan encourages Medical Group to discuss with Members treatment options and their

associated risks and benefits, regardless of whether the treatment is covered under the Members Benefit Contract. Nothing in this Agreement is intended to interfere with Medical Group's relationship with Members as patients of Medical Group or with Plan's ability to administer its quality improvement, utilization management and credentialing programs.

10.8 *Appendices*. Additional and/or alternative provisions, if any, related to certain Health Services rendered by Medical Group to Members covered by certain Benefit Contracts are set forth in the appendices.

10.9 *Entire Agreement*. This Agreement constitutes the entire agreement between the parties in regard to its subject matter.

10.10 *Governing Law*. This Agreement shall be governed by and construed in accordance with Florida law and ERISA.

10.11 *Medicare Members*. If a Medicare Appendix is attached to this Agreement, Medical Group agrees to provide Health Services to Members and to cooperate with Plan in providing any information and/or notices to Members who are enrolled in a Medicare HMO benefit program unless specified in the Benefit Contract. Medical Group also understands that Plan's agreements with Participating Providers are subject to review and approval by the Health Care Financing Administration ("HCFA").

10.12 *Medicaid Members*. If a Medicaid Appendix is attached to this Agreement Medical Group agrees to provide Health Services to Members enrolled in Plan's Medicaid benefit program and to comply with any additional requirements set forth in the Medicaid Appendix attached to this Agreement. Medical Group also understands that Plan's agreements with Participating Providers are subject to review and inspection by the appropriate state and federal regulatory agencies.

10.13 *Limited Procedures*. Plan shall notify Medical Group in writing of any limitation, restriction and/or condition placed upon Medical Group with respect to the provision of specific Health Services to Members. Any additional and/or alternative provisions related to Health Services rendered by Medical Group to Members covered by certain Benefit Contracts are set forth in the appendices.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

United HealthCare of Florida, Inc. 13621 Northwest 12th Street Sunrise, FL 33323	Community Orthopedics & Pain Management, Inc. 7421 N. University Drive Suite [handwritten: 107] Tamarac, Florida 33321 Tax ID 65-0796980
By: [handwritten signature: illegible name]	By: [handwritten signature: Porth MD]
Its: [handwritten: Dir. of Contracting]	Its: [handwritten: President]
Date: [handwritten: 6/29/98]	Date: [handwritten: 6/12/98]

MEDICAL GROUP PHYSICIAN PARTICIPATION ADDENDUM

THIS ADDENDUM, effective [handwritten: 8/1/98] is made between Plan, Community Orthopaedics & Pain Management, Inc. (Medical Group), and Manuel Porth, M.D. ("Medical Group Physician") for the purpose of setting forth the terms and conditions under which Medical Group Physician shall render Health Services to Members.

1. *Credentialing*. Medical Group shall supply all information requested by Plan for the purpose of credentialing Medical Group Physician. Medical Group Physician must be approved for participation by Plan in writing before rendering Health Services to Members.

2. *Rights and Obligations*. Medical Group Physician shall have the rights and obligations provided in the Agreement which are applicable to Medical Group. Medical Group Physician understands that certain provisions of the Agreement shall also be individually binding on Medical Group Physician and that Plan may require performance of all provisions by Medical Group Physician. Medical Group Physician also understands that Plan and Medical Group may amend the Agreement, without right of review by or approval of Medical Group Physician.

3. *Reimbursement*. Medical Group Physician agrees to look solely to Medical Group for reimbursement for Health Services provided to Members.

United HealthCare of
Florida, Inc.
13621 Northwest 12th Street
Sunrise, FL 33323

By: [handwritten signature:
illegible name]

Its: [handwritten:
Dir. of Contracting]

Date: [handwritten: *6/29/98*]

Community Orthopaedics &
Pain Management, Inc.
7421 N. University Drive
Suite [handwritten: 107] ~~304~~
Tamarac, Florida 33321

By: [handwritten signature:
Porth MD

Its: _____

Date: [handwritten: *6/12/98*]
Manuel Porth, M.D.
SS#: [handwritten:
366-40 2694]
License: [handwritten:
0028637]
By: : [handwritten signature:
Porth MD

Date: [handwritten: *6/12/98*]

EXHIBIT I
NETWORKS OF PARTICIPATING PROVIDERS

Medical Group shall participate in the networks of Participating Providers established by Plan for the Benefit Contract types identified below:

- Benefit Contracts where Members are offered a network of Participating Providers and must select a Primary Care Physician. The Primary Care Physician coordinates the Member's care and approves the rendering of Health Services to Members by other Participating Providers. An option for this Benefit Contract allows the Member to receive Health Services from a Participating or non-Participating Provider, without the approval of the Primary Care Physician.
- Benefit Contracts where Members are offered a network of Participating Providers but are not required to select a Primary Care Physician. The Member may receive Health Services from a Participating Provider of his or her choice. An option for this Benefit Contract allows the Member to receive Health Services from non-Participating Providers.
- Benefit Contracts where Members are not offered a network of Participating Providers from which they may receive Health Services.
- Benefit Contracts for Medicaid Members.
- Benefit Contracts for Medicare Members.

EXHIBIT 2
MEDICAL OFFICE LOCATIONS

7421 North University Drive
Suite -304[handwritten: *107*]
Tamarac, Florida 33321
Phone: (954) 724-3400
Fax: (954) 724-9451

ELDERCARE APPENDIX

APPLICABILITY

The provisions of this Appendix apply to Health Services rendered by Medical Group to Members covered by Benefit Contracts sponsored or issued by Plan for its ElderCare program.

SECTION 1
PAYMENT

1.1 For the provision of Health Services rendered to Members covered under Plan's ElderCare program, Medical Group shall be paid by Payor and/or Medicare as follows:

Type of Coverage:	Medicare Responsibility:	Payor Responsibility:
ElderCare + Medicare Parts A and B	Bill Medicare	The Medicare deductible upon submission of an explanation of Medicare benefits and an invoice. Coinsurance will not be reimbursed.
ElderCare + Medicare Part B	Bill Medicare for Part B	The Medicare deductible upon submission of an explanation or Medicare benefits and an invoice. Coinsurance will not be reimbursed.
ElderCare + No Medicare	Not Applicable	Medicaid rate of payment set forth in the Agency Medicaid reimbursement schedule.

1.2 The additional requirements set forth in the Medicaid Appendix shall be applicable to Health Services rendered to the Members described herein; however, payment shall be provided for in this Appendix.

MEDICARE APPENDIX
FEE MAXIMUM

APPLICABILITY

The provisions of this appendix apply to Health Services rendered by Medical Group to Plan Medicare Members and Affiliated Medicare Members pursuant to a contract with HCFA.

SECTION 1
ADDITIONAL DEFINITIONS

Affiliated Health Plan: Health plan affiliated with Plan, either by common ownership or control or through a written agreement.

Affiliated Medicare Member: Member covered by a Benefit Contract sponsored, issued, or administered by an Affiliated Health Plan.

Fee Maximum: Maximum fee for Health Services rendered by Participating Providers to Plan Medicare Members, as determined from time-to-time by Plan. A sample of the most recent Fee Maximum schedule is available to Medical Group upon request.

Plan Medicare Member: Member covered by a Benefit Contract sponsored, issued, or administered by Plan.

SECTION 2
PAYMENT PROVISIONS

2.1 *Payment for Health Services Rendered to Plan Medicare Members*. Payor shall pay Medical Group for Health Services rendered to Plan Medicare Members the lesser of Medical Group's Customary Charge or the Fee Maximum for such Health Services.

2.2 *Payment for Health Services Rendered to Affiliated Medicare Members*. For the provision of Health Services to Affiliated Medicare Members, Medical Group shall be paid

by the Affiliated Health Plan the applicable Medicare allowable rates for such Health Services, less any applicable Member Expenses, which shall be collected by Medical Group directly from the Affiliated Medicare Members.

MEDICAID APPENDIX

APPLICABILITY

The provisions of this appendix apply to Health Services rendered by Medical Group to Members enrolled in Plan's Medicaid HMO benefit program. Such Members, the counties served and the benefit program are defined in Plan's contract with the Agency for Health Care Administration ("AHCA")

SECTION 1
ADDITIONAL REQUIREMENTS

1.1 *Provision of Health Services*. Medical Group agrees to provide Health Services to Members and to comply with all applicable conditions stated in this appendix. Medical Group shall provide for timely access to appointments in accordance with the following availability schedule: urgent care - within one day; routine sick care - within one week; well care—within one month.

1.2 *Payment for Health Services*. For the provision of Health Services rendered to Members Medical Group shall be paid pursuant to this appendix.

Medical Group shall look solely to Plan for payment of Health Services provided to Members pursuant to this appendix and will hold AHCA, the Department of Health and Human Services ("DHHS") and Members harmless in the event that Plan cannot or will not pay for such Health Services.

1.3 *Workers' Compensation Insurance*. During the term of the Agreement, Medical Group agrees to maintain workers' compensation insurance for all of its employees connected with the services under this contract. Such insurance shall comply with Florida's Workers' Compensation Law.

1.4 *Liability for Damages.* Medical Group shall indemnify and hold AHCA and Members harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause survives the termination of the Agreement, including breach due to insolvency.

1.5 *Inspection of Facilities.* Medical Group shall permit AHCA's designated representatives to access Medical Group's facilities, upon reasonable advance notice, to evaluate through inspection or other means the quality, appropriateness and timeliness of services performed.

1.6 *Maintenance of Records.* Medical Group shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Members.

1.7 *Reporting on Number of Active Patient.* Medical Group shall inform Plan when the number of active patients from all populations serviced by Medical Group reaches 2,500 active patients. This ratio may be increased by 500 patients for each full-time employee advance registered nurse practitioner or full-time employee physician assistant affiliated with Medical Group as a provider in the practice, with a maximum capacity of 3,000 active patients. Active patients are those who have been seen at least three times per year. Payor will riot assign any new Medicaid Members to Medical Group until his/her patient load drops below 2,500 or 3,000 when Medical Group employs an advanced nurse practitioner or physician assistant.

SECTION 2
PAYMENT FOR HEALTH SERVICES

2.1 *Payment for Health Services.* Payor shall pay Medical Group for Health Services rendered to Members the lesser of Medical Group's Customary Charge or the Fee Maximum for such Health Services.

ALL PAYOR APPENDIX
FEE MAXIMUM

APPLICABILITY

Unless another appendix to this Agreement applies specifically to certain Members, the provisions of this appendix apply to Health Services rendered by Medical Group to Members covered by Benefit Contracts sponsored, issued, or administered by all Payors.

SECTION 1
ADDITIONAL DEFINITIONS

Fee Maximum: Maximum fee for Health Services rendered by Participating Providers, as determined from time-to-time by Plan. The Fee Maximum for the same Health Service rendered pursuant to different Benefit Contracts may vary. A sample of the most recent Fee Maximum is available to Medical Group upon request.

SECTION 2
PAYMENT PROVISIONS

2.1 *Payment for Health Services.* Payor shall pay Medical Group for Health Services rendered to a Member the lesser of Medical Group's Customary Charge, less any applicable Member Expenses, or the Fee Maximum for such Health Services, less any applicable Member Expenses.

PLAN MEDICARE+CHOICE ADDENDUM

The provisions of this Addendum apply to health care services rendered by Provider (for purposes of this Addendum, the "Provider"), on or after January 1, 1999, to individuals covered under a UnitedHealthcare of Florida. Inc. ("Plan") benefit plan pursuant to its Medicare+Choice contract ("Plan M+C Contract") with the Health Care Financing Administration ("HCFA"). With respect to the rendering of health care services to such individuals, the provisions of this Addendum shall prevail over any provision in the Agreement which may conflict or appear inconsistent with any provision in this Addendum.

DEFINITIONS

The following terms are defined for the purpose of this Addendum only:

Benefit Contract: A benefit plan of health care coverage for Medicare beneficiaries that is sponsored, issued or administered by Plan and contains the terms and conditions of a Plan M+C Member's coverage.

Health Services: The health care services and supplies which a Plan M+C Member is entitled to receive pursuant to his or her Benefit Contract.

Member Expenses: Any amounts that are the Plan M+C Member's responsibility to pay Provider in accordance with his or her Benefit Contract, including copayments, coinsurance and deductibles.

Participating Provider: A health care professional or facility, including Provider, that has a written participation agreement in effect with Plan, directly or through another entity, to provide Health Services to Plan M+C Members.

Plan Medicare+Choice ("Plan M+C") Member: An individual who is properly enrolled for coverage under a Benefit Contract.

PROVISIONS

1. *Provision of Health Services.* Provider agrees to provide or arrange for the provision of Health Services to Plan M+C Members in accordance with the terms set forth in the Agreement and this Addendum, and in a manner consistent with professionally recognized standards of health care. Provider shall provide Health Services to all Plan M+C Members on the same basis as Provider is accepting non-Plan M+C Members as new patients without regard to race, ethnicity, religion, gender, color, national origin, age, sexual orientation, genetic information, source of payment, any factor related to physical or mental health status, or on any other basis deemed unlawful under federal, state or local law.

2. *Access to Care.* Provider shall cooperate with Plan's written standards for timely access to care and services by Plan M+C Members. Where Benefit Contracts require certain services to be provided only upon the referral of a primary care physician, the following Health Services may be provided to Plan M+C Members without such a referral: (1) screening mammography and influenza vaccination Health Service; and (2) for women, routine and preventive Health Services from a Participating Provider that is a women's health specialist. No Member Expenses shall apply to influenza and pneumococcal vaccines.

3. *Cooperation With Processes, Policies and Programs.* Provider shall cooperate with the following: (1) all credentialing and recredentialing processes and all medical management, quality assessment and

performance improvement, medical policy, peer review, on site review, advance directives, or other similar HCFA or Plan policies and programs; (2) Plan's member grievance and appeal/expedited appeal processes, including gathering and forwarding information to Plan on a basis that will permit Plan to meet HCFA required timeframes for disposition of grievances and appeals; (3) the activities of any independent quality review and improvement organization approved by HCFA that is under contract with Plan; (4) as applicable, Plan's processes for identifying Plan M+C Members with complex or serious medical conditions, assessment of those conditions, and establishment and implementation of a treatment plan appropriate to those conditions; and (5) Plan's processes for conducting an initial assessment of each Plan M+C Member's health care needs within 90 days of the effective date of their enrollment. From time to time, Plan shall consult with Participating Providers, as appropriate, regarding Plan's medical policy, quality assurance program and medical management procedures.

4. *Data Collection Requirements.* Provider acknowledges that Plan is required by HCFA to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as HCFA may require from time to time. Provider hereby agrees to submit to Plan, upon request, all data necessary for Plan to fulfill these obligations, and within the timeframes specified by Plan to meet HCFA requirements. Provider hereby represents and warrants, and to the extent required by Plan, hereby agrees to certify in waiting at the time of submission to Plan or its designee, that all data including, but not limited to,

encounter data and other information that HCFA may specify, shall be truthful, reliable, accurate and complete. Provider further agrees to hold harmless and indemnify Plan for any fines or penalties it may incur due to Provider's submission of inaccurate or incomplete data.

5. *Compliance with Protocols*. Provider shall cooperate and comply with the protocols of Plan, which include, but are not limited to:

   (a) All protocols referenced in the Agreement, as applicable.

   (b) Any provider manual and credentialing plan, as modified from time to time by Plan.

   (c) If Provider is a Plan M+C Member's primary care physician, Provider agrees to provide or arrange for the provision of advice and assistance to Plan M+C Members in emergency situations, and arrange for on-call coverage, 24 hours per day, 7 days per week.

6. *Consequences for Failure to Cooperate*. Failure to cooperate and comply with any of the provisions of the Agreement and this Addendum including, but not limited to, sections 2, 3, 4 and 5 above, may result in denial of payment to Provider and/or termination of Provider's participation in the Plan Medicare+Choice network of Participating Providers in accordance with the Agreement and this Addendum. If any payment to Provider is denied due to failure to co[illegible]ly with any of the provisions of the Agreement or this Addendum, Provider shall not bill the Plan M+C Member for the denied amount.

7. *Payment*. For the provision of Health Services to Plan M+C Members, Provider shaft be paid in accordance with the existing payment arrangement for Medicare Members, as set forth in the Agreement. If no time frame for payment is set forth in the existing arrangement, payment to Provider for Health Services rendered to Plan M+C Members shall be made promptly (but no later than 60 days) after receipt of all information necessary to process and pay the claim, unless a shorter time frame is required by applicable statutes and regulations. Member Expenses, if any, may be collected directly from the Plan M+C Member. Provider incentive arrangements, if any, are set forth in the Agreement. Any additional information related to Provider's payment arrangement (such as a particular fee schedule amount) is available by contacting Plan. If Provider is responsible for making payment to subcontracted providers for Health Services provided to Plan M+C Members, then Provider shall make such payments in accordance with this provision. Provider shall ensure that payment and incentive arrangements with subcontractors, if any, are specified in a written agreement. Additional information regarding payment and incentive payments to subcontracted providers must be made available to the subcontracted providers upon request.

8. *Member Protection and Continuation of Benefits*. Provider agrees that in no event, including, but not limited to, non-payment by Plan or an intermediary, insolvency of Plan or an intermediary, or breach by Plan of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Plan M+C Member or person (other than Plan or an intermediary) acting on behalf of the Plan M+C Member for Health Services provided

pursuant to this Agreement. This provision does not prohibit Provider from collecting Member Expenses or fees for services not covered under the Plan M+C Member's Benefit Contract and delivered on a fee-for-service basis to the Plan M+C Member. This provision does not prohibit Provider and a Plan M+C Member from agreeing to continue services solely at the expense of the Plan M+C Member, as long as Provider has clearly informed the Plan M+C Member that the Benefit Contract may not cover or continue to cover a specific service or services, and documentation of Provider's conversation with the Plan M+C Member is made available to Plan upon request.

In the event of Plan's or an intermediary's insolvency or other cessation of operations or termination of the Plan M+C Contract, Provider will continue to provide Health Services to Plan M+C Members through the period for which premium has been paid to Plan on behalf of the Plan M+C Member, or, in the case of Plan M+C Members who are hospitalized as of such period or date, until the Plan M+C Member's discharge from an inpatient facility, whichever time is greater. Covered benefits for Plan M+C Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

The provisions of this section shall be construed in favor of the Plan M+C Member, shall survive the termination of this Agreement regardless of the reason for termination, including the insolvency of Plan, and shall supersede any oral or written contrary agreement between Provider and a Plan M+C Member or the representative of a Plan M+C Member if the contrary agreement is inconsistent with this section.

For the purpose of this section, an "intermediary" is defined as a person or entity authorized to negotiate and execute this Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

9. *Private Contracts*. Plan may not pay, directly or indirectly, on any basis, for services rendered by Provider to a Plan M+C Member if Provider files or is required to file an affidavit with a Medicare carrier agreeing to furnish Medicare covered services to any Medicare beneficiary through a private contract, except that payment may be made by Plan for emergency and urgent care services. Such payment shall be limited to the Medicare allowable charge.

10. *Excluded Individuals*. Provider is prohibited from employing or contracting with an individual who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following: (1) health care; (2) utilization review; (3) medical social work; or (4) administrative services.

11. *Laws and Regulations*. Provider and Plan shall each maintain, without material restriction, all applicable federal, state and local licenses, certifications and permits which are required to fulfill their obligations under the Agreement and this Addendum in the applicable jurisdiction. Provider shall comply with all applicable Medicare laws, regulations and HCFA instructions, and all applicable federal, state and local laws, rules and regulations including, but not limited to, Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, and The Americans With Disabilities Act. Provider shall also cooperate with Plan in its efforts to comply with the laws, regulations and other requirements of applicable regulatory

authorities. Provider shall require that all health care professionals employed by or under contract with Provider to render Health Services to Plan M+C Members, including covering physicians, comply with this provision.

12. *Records*.

(a) *Maintenance and Accuracy Records*. Provider will maintain adequate medical, financial and administrative records related to the services rendered by Provider under the Agreement and this Addendum in an accurate and timely manner.

(b) *Access to Records*.

(i) Plan, The Secretary of Health and Human Services (the "Secretary"), the Comptroller General or their designees shall have the right to audit, evaluate or inspect any books, contracts, medical records, patient care documentation and other records of Provider that pertain to: (1) the services performed under the Agreement and this Addendum; (2) reconciliation of benefit liabilities; (3) determination of amounts payable; or (4) other relevant matters as such person conducting the audit, evaluation or inspection deems necessary.

(ii) The right described above shall extend through 6 years from the final date of the applicable Plan M+C Contract period or completion of audit, whichever is later; provided, however, that such access may be required for a longer time period if: (1) HCFA determines that there is a special need to retain a particular record or group of records for a longer period and HCFA provides notice at least 30 days before the normal disposition date; (2) HCFA determines that there has been a termination, dispute, fraud or similar fault, in

which case the retention may be extended to 6 years from the date of any resulting final resolution of the matter; or (3) HCFA determines that there is a reasonable possibility of fraud, in which case it may perform the inspection, evaluation or audit at any time.

(iii) For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to Plan, M+C Members, and any additional relevant information that Plan or HCFA may require.

(c) *Member Access to Records*. Provider also agrees to establish procedures to ensure timely access by Plan M+C Members to medical records and other health and enrollment information that pertains to them.

(d) *Confidentiality of Records*. Plan and Provider shall safeguard the privacy of any health information that identifies a particular Plan M+C Member. Plan and Provider shall abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollee information.

13. *Rules of Participation*. Plan's rules of participation are set forth in the Agreement and this Addendum, and in the provider manual and credentialing plan, which shall be made available to Provider from time to time. Written notice of material changes to the rules of participation shall be provided prior to the effective date of such changes.

14. *Additional Termination Provisions*. Notwithstanding any provision in the Agreement to the contrary, the following provisions shall apply to Provider's

participation in the Plan Medicare+Choice network of Participating Providers only:

(a) Provider's participation in the Plan Medicare+Choice network of Partici-pating Providers may be terminated by Plan immediately upon written notice to Provider due to: (1) loss or suspension of licensure or certification; (2) Provider sanction by Medicare; or (3) Provider entering into a private contract with any Medicare beneficiary; or

(b) Provider's participation in the Plan Medicare+Choice network of Partici-pating Providers may be terminated by Plan, upon 30 days prior written notice to Provider, due to failure to cooperate and comply with any of the provisions of the Agreement or this Addendum including, but not limited to, sections 2, 3, 4 and 5 of this Addendum.

(c) If the Agreement contains any provision permitting termination of the Agreement without cause, notice of such termination shall be given by either party in accordance with the applicable provision of the Agreement, but in no such case shall the notice period be less than 60 days prior to the termination date.

(d) If Provider is a physician, any written notice of Provider's suspension or termination shall include the following, to the extent applicable: (1) the reason for the suspension or termination; (2) the standards and profiling data used by Plan to evaluate Provider; (3) the numbers and mix of physicians needed in the network; (4) Provider's right to appeal the action; and (5) the process and timing for requesting a hearing.

15. *Acknowledgements and Delegated Activities. Provider acknowledges and agrees that*:

(a) Agreements with Participating Providers are subject to review and approval by HCFA.

(b) Plan receives payments in whole or in part from federal funds. Contractors and subcontractors, including Provider, are subject to certain laws that are applicable to individuals and entities receiving federal funds.

(c) Plan oversees and is accountable to HCFA for any functions or responsibilities that are contained in the Plan M+C Contract, including those that Plan may delegate to others. Activities or responsibilities under the Plan M+C Contract that are delegated by Plan to Provider must be set forth in a written agreement that contains, at a minimum, the following HCFA delegation requirements: (1) the specific delegated activities and reporting requirements; (2) a right of revocation of the delegation activities and reporting requirements in instances where HCFA or Plan determines that Provider has not performed satisfactorily; (3) a provision specifying that the performance of Provider is monitored by Plan on an ongoing basis; (4) a provision specifying that the credentialing process must be reviewed and approved by Plan, and Plan shall audit the credentialing process on an ongoing basis; and (5) a requirement that Provider must comply with all applicable Medicare laws, regulations and HCFA instructions. Any written delegation agreement between Plan and Provider is hereby amended to include these requirements.

16. *Regulatory Amendment*. Plan may amend this Addendum to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.

17. *Noninterference with Advice to Plan M+C Members*. Nothing in the Agreement arid this Addendum is intended to prohibit or restrict Provider from advising or advocating on behalf of a Plan M+C Member about (1) the Plan M+C Member's health status, medical care, or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the Plan M+C Member to provide an opportunity to decide among all relevart treatment options, (2) the risks, benefits and consequences of treatment or non-treatment, and (3) the opportunity for tine Plan M+C Member to refuse treatment and express preferences about future treatment decisions. Provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Provider must assure that individuals with disabilities are furnished with effective communications in making decisions regarding treatment options.

18. *Affiliated Health Plans*. To the extent the Agreement includes payment terms for the provision of health care services to individuals covered by Medicare plans affiliated with Plan, either by common ownership or control or

through a written agreement (each an "Affiliated Health Plan"), the requirements in this Addendum shall apply equally to services rendered to individuals enrolled in all Medicare+Choice Affiliated Health Plans.

19. *Individual Providers and Facilities*.

(a) If Provider is a medical group, facility or other entity whose staff of health care professionals consists wholly or partially of employees, Provider represents and warrants that it has the unqualified authority to bind all such employees to the terms of the Agreement and this Addendum. If Provider has any arrangements with subcontractors, as defined in subsection (b), below, to render Health Services to Plan M+C Members, Provider shall ensure that all such subcontracts are duly amended to incorporate the terms contained in this Addendum through one of the methods described in subsections (b)(i) and (b)(ii) below.

(b) If Provider is an independent practice association, physician hospital organization, or other intermediary or network organization contracting on behalf of health care providers and/or facilities, Provider shall ensure that all arrangements with subcontractors for participation in Plan's M+C network of Participating Providers are in writing and duly executed. A "subcontractor" is defined as a person or entity that is contracted by

Provider, directly or through another person or entity, to provide Health Services to Plan M+C Members, and that does not hold a direct contract with Plan. Provider shall ensure that all agreements with subcontractors are duly amended to incorporate the terms contained in this Addendum through one of the following methods:

(i) If the subcontract contains language that permits a unilateral amendment, Provider shall unilaterally amend each subcontract to include the terms of this Addendum. Such amendment shall be distributed by certified mail, return receipt requested, or through some other comparably verified process, and copies of such amendments and the receipts must be mailed to Plan no later than July 1, 1999 in order for Plan to verify that these requirements have been implemented.

(ii) If the subcontract does not contain language that permits unilateral amendment, Provider shall obtain a signed amendment for each subcontract to include the terms of this Addendum. Copies of the amendments, executed by all parties, must be mailed to Plan no later than July 1, 1999 in order for Plan to verify that these requirements have been implemented.

(c) Provider shall ensure that the terms of this Addendum are included in all future and

pending agreements with subcontractors who agree to provide services to Plan M+C Members. Provider further agrees to promptly amend the agreements with subcontractors, in the manner requested by Plan, to meet any additional HCFA requirements. Refusal of any subcontractor to agree to the terms in this Addendum, and any subsequent amendments, shall be grounds for the termination of such subcontractor from the Plan M+C network of Participating Providers.

UNITED HEALTHCARE OF COLORADO, INC.
PHYSICIAN PARTICIPATION AGREEMENT

THIS AGREEMENT, effective on the date specified at the signature portion of this Agreement ("Effective Date"), is between United HealthCare of Colorado, Inc. ("Plan") and [handwritten: *Glenn L. Kelly, M.D. PC*] ("Physician") and sets forth the terms and conditions under which Physician shall participate in one of more networks of providers developed by Plan to render health care services to Members, as defined in this Agreement. On the Effective Date, this Agreement supersedes and replaces any existing agreements between the parties related to the provision of health care services to Members. This Agreement also supersedes and replaces any existing agreements between Physician and the following entities to the extent such agreements relate to the provision of health care services to Members, and to the extent such entities sponsor, issue or administer a Benefit Contract, as defined in this Agreement: The MetraHealth Insurance Company (MHIC), The Travelers Insurance Company, Metropolitan Life Insurance Company, and United Health and Life Insurance Company.

SECTION 1

Definitions

Benefit Contract: A benefit plan that includes health care coverage, is sponsored, issued or administered by Payor and contains the terms and conditions of a Member's coverage.

Customary Charge: The fee for health care services charged by Physician that does not exceed the fee Physician would charge any other person regardless of whether the person is a Member.

Health Services: The health-care services and supplies covered by the Member's Benefit Contract.

Member: An individual who is properly covered under a Benefit Contract.

Member Expenses: Any amounts that the Member's responsibility to pay Physician in accordance with the Member's Benefit Contract, including copayments, coinsurance and deductibles.

Participating Provider: A health care professional or facility, including Physician, that has a written participation agreement in effect with Plan, directly or through another entity, to provide Health Services to selected groups of Members.

Payor: The entity or person authorized by Plan to access one or more networks of Participating Providers developed by Plan and that has the financial responsibility for payment of Health Services covered by a Benefit Contract.

Primary Care Physician: A Doctor of Medicine ("*M.D.*"), Doctor of Osteopathy ("*D.O.*") or another health care professional as required by applicable statutes and regulations, who is duly licensed and qualified under the laws of the jurisdiction in which Health Services are rendered and is a Participating Provider of primary care Health Services.

Referral Authorization: The approval by a Member's Primary Care Physician in a format determined by Payor, which may be an electronic format, for a health care professional or facility to render certain Health Services to the Member.

Referral Physician: An M.D. or a D.O. (1) who is a Participating Provider; (2) who is not a Primary Care Physician; and (3) to whom a Member is referred by a Primary Care Physician for the provision of certain Health Services.

SECTION 2

Networks of Participating Providers

Physician shall provide Health Services to Members covered under the Benefit Contract types described in Exhibit 1, which may be modified from time to time by Plan, and which includes, but is not limited to, Benefit Contracts which offer a network of Participating Providers. When appropriate, Physician will be listed in the applicable provider directories.

SECTION 3

Duties of Physician

3.1 *Member Status.* To determine whether an individual is a Member and, therefore, entitled to receive Health Services, Physician shall ask the individual to present his or her identification card, which shall be provided to all Members and Payors, unless because of the type of Benefit Contract under which the Member has coverage no identification card applies. In addition, Physician may con-tact Plan to obtain Plan's most current information on the individual as a Member. However, Physician acknowledges that such information is subject to change retroactively (1) if Plan does not receive proper and timely notification regarding termination of a Member's coverage; (2) as a result of the Member's final decision regarding continuation of coverage pursuant to state and federal laws; or (3) if eligibility information Plan receives on the individual is later proven to be false. If Physician provides health care services to an individual, and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Physician may then directly bill the responsible party for such services.

3.2 *Provision of Health Services.* Physician shall provide Health Services to all Members as Physician's patient

load and appointment calendar permit and shall accept Members as new patients on the same basis as Physician is accepting non-Members as new patients without regard of race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Physician shall require employed or subcontracted healthcare professionals and facilities to comply with the protocols and requirements of Plan and Payor and the requirements of all applicable regulatory authorities. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract.

3.3 *Utilization Management, Quality Improvement and Other Plan or Payor Programs.* Physician shall cooperate with all credentialing and recredentialing processes and all utilization management, quality improvement, peer review, Member grievance, on site review, or other similar Plan or Payor programs.

3.4 *Protocols.* Physician shall comply with protocols of Plan or Payor, including, but not limited to, the following:

3.4.1 Refer Members only to other Participating Providers unless otherwise authorized by Plan or Payor.

3.4.2 Be bound by any provider manual and credentialing plan, as modified from time to time by Plan or Payor.

3.4.3 Obtain prior authorization for certain Health Services as defined by Plan or Payor.

3.4.4 Follow approved billing procedures of Plan or Payor, as appropriate.

3.4.5 If Physician is a Primary Care Physician, Physician shall provide or arrange for the provision of advice and

assistance to Members in emergency situations 24 hours per day, 7 days per week.

3.4.6 If the Member's Benefit Contract requires the Member to receive certain Health Services from or upon referral by a Primary Care Physician, all Referral Physicians must adhere to the following additional protocols when those Health Services are provided:

1. Referrals to other Participating or non-Participating Providers must first be authorized by the Member's Primary Care Physician.

2. Health Services must be provided pursuant to the terms and limitations of the Referral Authorization.

3. Issued by or on the behalf of the Member's Primary Care Physician.

3.4.7 Physician shall comply with the following requirements when admitting Members to a hospital:

1. Admit Members on the day of surgery, unless the Member's medical condition requires otherwise and Physician has obtained prior authorization from Plan or Payor, as appropriate.

2. Notify Plan or Payor, as appropriate, by telephone at least 48 hours prior to a scheduled admission of a Member.

3. Notify Plan or Payor, as appropriate, immediately if Physician admits a Member to a hospital for an emergency or for observation.

4. If physician is a Referral Physician, Physician must also notify the Member's Primary Care Physician of all admissions in accordance with the above time frames.

Failure to comply with the above may result in denial of payment to Physician and/or termination of this Agreement. If any payment to Physician is denied due to Physician's

failure to comply with the above protocols, Physician shall not bill the Member for the denied amounts:

SECTION 4

Payment Provisions

4.1 *Payment.* For the provision of Health Services to a Member, Payor shall pay Physician the applicable amounts stated in the attached Appendices. The obligation for payment under this Agreement for Health Services rendered to a Member is solely that of Payor.

Physician shall accept in full for Health Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges which result from Payor's reimbursement methodologies. In no event shall Physician bill a Member for the difference between Customary Charges and the amount Physician has agreed to accept as full reimbursement under this Agreement. Physician may collect Member Expenses from the Member. If Payor denies payment for services rendered by Physician on grounds that the services are not medically necessary, as defined in the Member's Benefit Contract, Physician shall not collect payment from the Member for the services unless Physician first obtains the Member's written consent.

4.2 *Submission of Claims.* Physician shall submit claims for Health Services to Plan in a manner and format prescribed by Plan, which may be an electronic format. All information necessary to process the claims must be received by Plan no more than 90 days from the date the Health Services are rendered. Physician agrees that claims received after this time period may be rejected for payment, at Plan's and/or Payor's discretion.

Unless otherwise directed by Plan, Physician shall submit claims using current HCFA 1500 or UB92 forms, whichever

is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Physician shall include in a claim the Member number, Customary Charges for the Health Services rendered to a Member during a single instance of service, Physician's Federal Tax I.D. number and/or other identifiers requested by Plan.

Physician shall not bill the Member for Health Services if Physician fails to submit claims in accordance with the above provisions.

Payor shall have the right to make, and Physician shall have the right to request, corrective adjustments to a previous payment; provided, however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

4.3 *Coordination of Benefits.* Physician shall be paid in accordance with Payor's coordination of benefits rules.

4.4 *Financial Responsibility.* Plan shall notify Physician in writing if Plan determines that a Payor has failed to maintain its responsibility to pay for services rendered. Any services which have been rendered by Physician prior to and after such notification, and which were not paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Physician may bill the Member directly for such services.

4.5 *Member Protection Provision.* This provision supersedes and replaces the Financial Responsibility section when Plan is the Payor, when required by a specific Payor other than Plan, or when required pursuant to applicable statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for Health Services rendered to Members by Physician, insolvency of Payor, or breach by Plan of any term or

condition of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Health Services eligible for reimbursement under this Agreement; provided, however, that Physician may collect from the Member, Member Expenses or charges for services not covered under the Member's Benefit Contract.

The provisions of this section shall (1) apply to all Health Services rendered while this Agreement is in force; (2) with respect to Health Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Physician and a Member or person acting on a Member's behalf, that requires the Member to pay for such Health Services.

SECTION 5

Liability of Parties, Laws, Regulations and Licenses

5.1 *Physician Liability Insurance.* Physician shall procure and maintain, at Physician's sole expense, (1) medical malpractice insurance in the amounts of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) aggregate, and (2) comprehensive general and/or umbrella liability insurance in the amount of One Million Dollars ($1,000,000.00) per occurrence and aggregate. Physician shall also require that all health care professionals employed by or under contract with Physician to render Health Service to Members procure and maintain malpractice insurance, unless they are covered under Physician's insurance policies. Physician's and other health care professionals' medical malpractice insurance shall be either occurrence or claims made with an extended period

reporting option under such terms and conditions as may be reasonably required by Plan. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Physician shall submit to Plan in writing evidence of insurance coverage.

5.2 *Laws, Regulations and Licenses.* Physician shall maintain all federal, state and local licenses, certifications and permits, without material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Health Services are provided, and shall comply with all applicable statutes and regulations. Physician shall also require that all health care professionals employed by or under contract with Physician to render Health Services to Members, including covering physicians, comply with this provision.

SECTION 6

Notices

Physician shall notify Plan within 10 days of knowledge of the following:

6.1 Changes in liability insurance carriers, termination of, renewal of or any other material changes in Physician's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium.

6.2 Action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on Physician's licenses, certificates or permits by any government under which Physician is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Physician's staff privileges at any licensed hospital, nursing home or other facility at which Physician has staff privileges during the term of this Agreement.

6.3 A change in Physician's name, ownership or Federal Tax I.D. number.

6.4 Indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Physician's profession.

Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. The parties shall provide each other with proper addresses of all designees that should receive certain notices or communication instead of that party.

SECTION 7

Records

7.1 *Confidentiality of Records.* Plan and Physician shall maintain the confidentiality of all Member records in accordance with any applicable statutes and regulations.

7.2 *Maintenance of and Plan Access to Records.* Physician will maintain adequate medical, financial and administrative records related to Health Services rendered by Physician under this Agreement. In order to perform its utilization management and quality improvement activities, Plan shall have access to such information and records, including claims records, within 14 days from the date the request is made, except that, in the case of an audit by Plan such access shall be given at the time of the audit. If requested by Plan, Physician shall provide copies of such records free of charge. Unless a longer time period is required by applicable statutes or regulations, Plan shall have access to and the right to audit information and records during the term of this Agreement and for 3 years following its

termination. It is Physician's responsibility to obtain any Member consent required in order to provide Plan with requested information and records or copies of records.

7.3 *Government and Accrediting Agency Access to Records.* The federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "*NCQA*"), and any of their authorized representatives, shall have access to, and Plan and Physician are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of Plan or Physician, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Plan, Payor or Physician.

SECTION 8

Resolution of Disputes

Plan or Payor and Physician will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if Plan, Physician or any Payor that has consented in writing to binding arbitration wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in Arapahoe County, Colorado. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Plan procedures,

such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Physician before Physician may invoke his or her right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

SECTION 9

Term and Termination

9.1 *Term.* This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated as provided below.

9.2 *Termination.* This Agreement may be terminated as follows:

9.2.1 by mutual agreement of Plan and Physician.

9.2.2 by either party upon 90 days prior written notice to the other party.

9.2.3 by either party, in the event of a breach of this Agreement by the other party, upon 30 days prior written notice to the other party.

9.2.4 by Plan immediately upon written notice to Physician, due to Physician's loss or suspension of licensure or certification, or loss of insurance required under this Agreement.

9.2.5 by Physician upon 60 days prior written notice to Plan due to an amendment made to this Agreement pursuant to section 10.1.

9.2.6 by Plan in accordance with its credentialing process.

Plan shall have the right to notify Members of the termination of this Agreement.

SECTION 10

Miscellaneous

10.1 *Amendment.* Plan may amend this Agreement by sending a copy of the amendment to Physician at least 30 days prior to its effective date. The signature of Physician shall not be required. Plan may also amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Physician of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Physician will not be required.

10.2 *Assignment.* Plan may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with Plan. Physician may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of Plan, which consent shall not be unreasonably withheld.

10.3 *Administrative Responsibilities.* Plan may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

10.4 *Relationship Between Plan and Physician.* The relationship between Plan and Physician is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

10.5 *Name, Symbol and Service Mark.* During the term of this Agreement, Physician, Plan and Payor shall have the right to use each other's name solely to make public reference to Physician as a Participating Provider. Physician, Plan and

Payor shall not otherwise use each other's name, symbol or service mark without prior written approval.

10.6 *Confidentiality.* Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that (1) Physician may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates, and (2) Plan may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Contract, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.7 *Communication.* Plan encourages Physician to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Contract. Nothing in this Agreement is intended to interfere with Physician's relationship with Members as patients of Physician, or with Plan's ability to administer its quality improvement, utilization management and credentialing programs.

A. No Physician covered by this contract shall be prohibited from processing or expressing disagreement with a medical decision, medical policy, or medical practice of Plan or an entity representing or working for the Plan (e.g., a utilization review company).

B. Plan or an entity representing or working for the Plan shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the Physician covered by this contract.

C. Plan shall not terminate this contract because the Physician covered by this contract expresses disagreement with a decision by Plan or an entity representing or working

for such Plan to deny or limit benefits to a Member or because the Physician assists the Member to seek reconsideration of the Plan's decision, or because a Physician discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alter-natives, whether covered by the Member's Benefit Contract or not, policy provisions of a Member's Benefit Contract or a Physician's personal recommendation regarding selection of a health plan based on the Physician's personal knowledge of the health needs of such patients.

10.8 *Appendices.* Additional and/or alternative provisions, if any, related to certain Health Services rendered by Physician to Members covered by certain Benefit Contracts are set forth in the Appendices.

10.9 *Entire Agreement.* This Agreement constitutes the entire agreement between the parties in regard to its subject matter.

10.10 *Governing Law.* This Agreement shall be governed by and construed in accordance with applicable state law and ERISA.

10.11 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Physician agrees to provide Health Services to Members enrolled in a Benefit Contract for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

10.12 *Medicare Members.* If a Medicare Appendix is attached to this Agreement, Physician agrees to provide Health Services to Members who are enrolled in a Benefit Contract for Medicare beneficiaries. Physician also understands that Plan's agreements with Participating Providers are subject to review and approval by the Health Care Financing Administration ("HCFA").

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

The Effective Date of this Agreement is [handwritten: *5-5-97*] .

United HealthCare of Colorado, Inc
6251 Greenwood Plaza Boulevard.
Englewood, CO 80111
Signature [handwritten signature: *Terry L. Nimnicht*]
Print Name [typewritten: *Terry L. Nimnicht*]
Title [typewritten: *C.E.O.*]
Date [handwritten: *5-5-97*]

[handwritten: *Glenn L. Kelly, MD*]
[handwritten: *601 E. Hampden Av*]
[handwritten: *Englewood, CO 80110*]
(Name and Address of Physician)
Signature [handwritten signature: *Glenn L. Kelly*]
Print Name [handwritten: *Glenn L. Kelly, M.D.*]
Date [handwritten: *4-30-97*]
TIN # [*handwritten: 84-0827902*]

EXHIBIT 1

NETWORKS OF PARTICIPATING PROVIDERS

Physician shall participate in the networks of Participating Providers established by Plan for the Benefit Contract types identified below:

- Benefit Contracts where Members are offered a network of Participating Providers and must select a Primary Care Physician. The Primary Care Physician coordinates the Member's care and approves the rendering of Health Services to Members by other providers. An option for this Benefit Contract allows the Member to receive Health Services from a Participating or non-Participating Provider, without the approval of the Primary Care Physician.
- Benefit Contracts where Members are offered a network of Participating Providers but are not required to select a Primary Care Physician. The Member may receive Health Services from a Participating Provider of his or her choice. An option for this Benefit Contract allows the Member to receive Health Services from non-Participating Providers.
- Benefit Contracts where Members are not offered a network of Participating Providers from which they may receive Health Services.
- Benefit Contracts for Medicare Members.
- Benefit Contracts for Medicaid Members.

ALL PAYOR APPENDIX

FEE MAXIMUM

APPLICABILITY

Unless another Appendix to this Agreement applies specifically to certain Members, the provisions of this Appendix apply to Health Services rendered by Physician to Members covered by Benefit Contracts sponsored, issued or administered by all Payors.

SECTION 1

Definitions

Fee Maximums: The maximum fees for Health Services rendered by Participating Providers, as determined from time to time by Plan. The Fee Maximums for the same Health Service rendered pursuant to different Benefit Contracts may vary. Samples of the most recent Fee Maximums are attached as Exhibit 2.

SECTION 2

Payment

Payor shall pay Physician for Health Services rendered to a Member the lesser of (1) Physician's Customary Charge, less any applicable Member Expenses, or (2) the Fee Maximum for such Health Services, less any applicable Member Expenses as listed in Exhibit 2.

UNITED HEALTHCARE OF COLORADO
SPC FEE SCHEDULE EXHIBIT 2

Anesthesiology	$32.00
Obstetrics	$1,800 global fee
MRI/CT reading	$100.00
Lab	National Reference Lab Fee Schedule
Physical Therapy	National Therapy Fee Schedule

For POS/PPO patients: All tests allowed in office.
For all HMO patients: The following tests may be performed in office:

81000	81001	81002	81003	81025
82270	82947	82948	85048	86403
87220	85204	85014	85018	85021
85022	85023	85025	86588	87081
87210	87220	88300-88309 Dermatologists only)		
85060 (Hematologists only)				

All other tests should be sent to Corning and will be declined if performed in office.

Immunizations:	90708-90712	$30.00	90735	$20.00
	90726	$40.00	90733	$30.00
	90727	$20.00	90732	$30.00
	90728-90730	$40.00	90731	$40.00
	90742	$50.00	90700-90701	$30.00
	90702-90703	$15.00	90707	$50.00
	90713-90714	$20.00	90716	$50.00
	90717	$30.00	90718-90719	$20.00
	90724-90725	$20.00	90737-90741	$30.00

Primary codes:	99381	$64.32	99393	$49.94
	99382	$64.32	99394	$50.51
	99383	$55.10	99395	$55.10
	99384	$55.10	99396	$59.70
	99385	$73.47	99397	$68.88
	99386	$78.02	99391	$36.73
	99387	$87.19	99392	$36.73

Remainder of reimbursement will be based on 1997 RBRVS at a following conversion factors with a Medicare applied Colorado geographical adjustment of .97:
Primary codes $38.63 Surgical codes $44.24 Non-surgical codes $36.55

MEDICARE APPENDIX
FEE MAXIMUM

APPLICABILITY

The provisions of this Appendix apply Health Services rendered by Physician to Members covered by Benefit Contracts sponsored or issued by (1) Plan pursuant to its risk contract with the Health Care Financing Administration ("*Plan Medicare Members*"), and (2) a health plan affiliated with Plan, either by common ownership or control or through a written agreement. ("*Affiliated Health Plan*") pursuant to its contract with the Health Care Financing Administration ("*Affiliated Medicare Members*").

SECTION 1
Definitions

Fee Maximums: The maximum fees for Health Services rendered by Participating Providers to Plan Medicare Members, as determined from time to time by Plan. A sample of the most recent Fee Maximum schedule is attached as Exhibit 3.

SECTION 2
Payment

1. Payor shall pay Physician for Health Services rendered to Plan Medicare Member the lesser of (1) Physician's Customary Charge, less any applicable Member Expenses, or (2) the Fee Maximum for such Health Services, less any applicable Member Expenses as listed in Exhibit 3.

2. For the provision of Health Services to Affiliated Medicare Members, Physician shall be paid by the Affiliated Health Plan the applicable Medicare allowable rates for such Health Services, less any applicable Member Expenses, which shall be collected by Physician directly from the Affiliated Medicare Members.

UNITED HEALTHCARE MEDICARE FEE SCHEDULE
EXHIBIT 3

Reimbursement will be based on 1997 Medicare at the following conversion factors:

Specialist Physicians

Surgical	$36.86
Non-surgical	$30.46
Primary codes	$32.18

The following payment will be used in those areas that do not reflect Medicare set allowables:

- Lab tests will be reimbursed at the national contracted lab allowables.
- Drugs, medications and immunizations will be reimbursed at AWP.
- Durable medical equipment, home care and infusion (all hcpcs codes) will be reimbursed at the national contracted dme/home care allowables.
- Preventive codes are United HealthCare modified RVU's.

Immunizations:	90708-90712	$30.00	90735	$20.00
	90726	$40.00	90733	$30.00
	90727	$20.00	90732	$30.00
	90728-90730	$40.00	90731	$40.00
	90742	$50.00	90700-90701	$30.00
	90702-90703	$15.00	90707	$50.00
	90713-90714	$20.00	90716	$50.00
	90717	$30.00	90718-90719	$20.00
	90724-90725	$20.00	90737-90741	$30.00

PHYSICIAN GAINSHARING PROGRAM

Physicians may be eligible for the gainsharing program. This program is intended to be used to make available an extra payment for those Providers who meet standards for high quality, cost effective care. Any gainsharing is contingent upon the profitability of United HealthCare as a whole. The size of the gainsharing pool to be distributed is contingent upon the profitability of United HealthCare's Medicare Risk book of business.

Gainsharing eligibility in the plan is limited to those Providers who are accepting all new beneficiaries on an ongoing basis. Gainsharing is based on the physician meeting the performance measures and will be distributed up to 10% of the available pool.

Performance Measures

A.	Quality of Care and Service	8%
B.	Adherence to Protocols and Practices	2%
	Total	10%

Quality of Care and Service:

- Adult Preventative Assessment > 90% 1/2%
- Medical Record Review Score > 85% 1/2%
- Plan meets monthly with physician subgroup to discuss
- quality initiatives 1/2%
- member specific quality of care issues 1/2%
- utilization patterns, specifically regarding 1/2%
- under and over utilization trends
- Member grievances less than 1.00 per 1000 1%
- members
- Disenrollment less than 4% 1%
- Appointment availability
- no informal complaints regarding availability 1/2%
- no formal complaints nor grievances regarding 1/2%
- availability

- plan on site survey indicates appropriate 1/2%
- availability
- On site survey score greater than 90% 1%
- Cooperate with Physician subgroup's initiatives or recommendations 1%
- Adherence to Protocols and Practices:
- No repeated incidents of provider non-compliance 1%
- No incidents of referral out of network 1%

In its sole discretion, United HealthCare reserves the sole right to change or modify the distribution of any gainsharing including all criteria and its weighting. United HealthCare also reserves the right to terminate the gainsharing program at any time without notice.

MEDICAID APPENDIX
FEE MAXIMUM

APPLICABILITY

The provisions of this Appendix to apply to Health Services rendered by Medical Group to Members covered by Benefit Contracts sponsored or issued by (1) Plan pursuant to its risk contract with the State Medicaid Agency ("*Plan Medicaid Members*"), and (2) a health plan affiliated with Plan, either by common ownership or control or through a written agreement, ("*Affiliated Health Plan*") pursuant to its contract with the State Medicaid Agency ("*Affiliated Medicaid Members*"). Participating Providers will not close their practice to Plan Medicaid Members until 200 Plan Medicaid Members are enrolled with the Participating Provider.

SECTION 1
Definitions

Fee Maximums: The maximum fees for Health Services rendered by Participating Providers to Plan Medicaid Members, as determined from time to time by Plan. A sample of the most recent Fee Maximum schedule is attached as Exhibit 4.

SECTION 2
Payment

1. Payor shall pay Medical Group for Health Services rendered to Plan Medicaid Member the lesser of (1) Medical Group's Customary Charge, less any applicable Member Expenses, or (2) the Fee Maximum for such Health Services, less any applicable Member Expenses as listed in Exhibit 4.

2. For the provisions of Health Services to Affiliated Medicaid Members, Medical Group shall be paid by the Affiliated Health Plan the applicable Medicaid allowable

rates for such Health Services, less any applicable Member Expenses, which shall be collected by Medical Group directly from the Affiliated Medicaid Members.

United Healthcare Medicaid Fee Schedule

Exhibit 4

Reimbursement will be based on 1997 Medicare at the following conversion factors:

Specialist Physicians

Surgical	$32.76
Non-surgical	$27.07
Primary codes	$28.60

The following payment will be used in those areas that do not reflect Medicare set allowables:

- Lab tests will be reimbursed at the national contracted lab allowables.
- Drugs, medications and immunizations will be reimbursed at AWP.
- Durable medical equipment, home care and infusion (all hcpcs codes) will be reimbursed at the national contracted dme/home care allowables.
- Preventative codes are United HealthCare modified RVU's.

Immunizations:	90708-90712	$30.00	90735	$20.00
	90726	$40.00	90733	$30.00
	90727	$20.00	90732	$30.00
	90728-90730	$40.00	90731	$40.00
	90742	$50.00	90700-90701	$30.00
	90702-90703	$15.00	90707	$50.00
	90713-90714	$20.00	90716	$50.00
	90717	$30.00	90718-90719	$20.00
	90724-90725	$20.00	90737-90741	$30.00

45/295P